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UCLA CENTER FOR HEALTH POLICY RESEARCH

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THIS REPORT IS DEDICATED TO OUR ESTEEMED COLLEAGUE, MENTOR, AND FRIEND
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OVERVIEW

In 1999, 6.8 million nonelderly Californians were uninsured, down from 7.3 million the previous year. This drop in the number of uninsured was the result of a 2.3 percentage-point gain in employment-based health insurance coverage and a slower decline in Medi-Cal coverage compared to the previous several years. California's recent upturn in coverage follows years of persistent and rising rates of uninsurance, despite the booming economy during this period.

Between 1994 and 1999, coverage from job-based insurance and public programs changed significantly.

- The rate of job-based coverage rose faster between 1998 and 1999 (from 58.3% to 60.6%) than between 1994 and 1998 (from 56.4% to 58.3%). This pattern reflects the state's recovery from the recession of the early 1990s, and a strengthening economy in subsequent years.
- Privately purchased health insurance has remained statistically unchanged between 1994 (4.3%) and 1999 (4.7%).
- Medi-Cal fell dramatically from 14.4% in 1994 to 12.8% in 1996, and continued to drop to 11.0% in 1998. This may have been in part due to the direct, anticipated and perceived effects of public policy changes that restricted Medicaid eligibility among immigrants during this period. However, this decline is slowing, with no significant drop between 1998 and 1999 in reported coverage from Medi-Cal or Healthy Families, California's State Children's Health Insurance Program initiated in mid-1998.

CALIFORNIA'S UNINSURED POPULATION

California's uninsured rate dipped from 24.4% in 1998 to 22.4% in 1999, but this rate is still no lower than in 1996. Moreover, compared to the United States as a whole, California's nonelderly population has a higher uninsured rate (22.4% vs. 17.4%). California has the fourth highest uninsured rate in the nation.

- Over eight in 10 of the uninsured — a total of 5.8 million Californians — are workers and their family members.
- Over two in three had family incomes under 250% federal poverty level in 1999, an income too low to make health insurance coverage affordable without substantial assistance from an employer and/or government.
- Large ethnic and racial disparities in coverage are reflected in the generally higher uninsured rates among people of color compared to non-Latino whites (13%). Uninsured rates are particularly high among Latinos (36%) and among Koreans (45%).
- Within the state, regions and counties also differ markedly in their coverage rates, with Southern California having lower job-based coverage and higher uninsurance than the other regions.

Economically vulnerable groups of Californians are far less likely to have job-based health insurance coverage

CHILDREN'S COVERAGE

Among California's children, 1.85 million have no private or public health care coverage of any kind. Children in California have a higher uninsured rate than in the nation as a whole (19% versus 14% in 1999). Although children's uninsured rate declined between 1998 and 1999, it remains higher than in 1995.

Uninsurance among children remained high during this period of sustained economic growth. This occurred because the gains in their coverage through a parent's job-based insurance, which rose from 50% in 1994 to 56% in 1999, was offset by plummeting Medi-Cal coverage, which fell from 25% in 1994 to 19% in 1999. Between 1998 and 1999, children's uninsured rate declined significantly as job-based coverage increased and the decline in public coverage slowed.

- Nine in 10 uninsured children are in working families.
- Seven in 10 uninsured children are in low- to moderate-income families with incomes below 250% the poverty level, an income too low for most families to afford health insurance coverage for their children without a substantial subsidy from an employer and/or government.
- Latino children continue to have the highest uninsured rate (28%), a rate that has not improved since 1994. Between 1994 and 1999, uninsured rates worsened for Asian-American and Pacific Islander children and for African-American children, while they improved among non-Latino white children.
- Children experience large disparities in health insurance coverage related to family immigrant and citizenship status. Four in ten noncitizen children and three in ten U.S.-citizen children with noncitizen parents were uninsured in 1999. These are three to four times the uninsured rate for citizen children with U.S.-born parents.
- There is a growing disparity between children in single-parent and married couple families. Uninsurance rose for children in single-parent families (from 22% in 1994 to 25% in 1999), while it declined for children in married couple families (from 18% in 1994 to 16% in 1999). The rise in uninsurance for children in single-parent families is due to a dramatic drop in Medi-Cal coverage (from 43% in 1994 to 35% in 1999), which was only partially offset by gains in job-based coverage (from 32% in 1994 to 36% in 1999).
- Uninsured rates and job-based coverage among children vary widely throughout the state. As with the nonelderly population overall, the Southern California region has higher rates than all other regions.
- More than two-thirds of California's 1.85 million uninsured children are eligible for either Medi-Cal or Healthy Families. A total of 535,000 uninsured children (range: 455,000 to 614,000) are eligible for Healthy Families, and 726,000 (range: 633,000 to 817,000) are eligible for Medi-Cal.[1] An estimated 343,000 uninsured children (range: 279,000 to 407,000) are citizens or legal immigrants who have family incomes that exceed the Medi-Cal and Healthy Families limits.

Californians lag behind the U.S. in job-based health insurance coverage

COVERAGE OF NONELDERLY ADULTS

Nonelderly adults, ages 19 to 64, face an even greater risk of being uninsured than do children. Although they are more likely than children to have job-based health insurance coverage, they are less likely to be eligible for public programs that protect children and the elderly.

- The 5 million uninsured adults account for three-fourths of the state's uninsured population.
- Young adults, ages 19-24, have the highest uninsured rates (38%) and lowest job-based insurance (48%), though coverage as dependents is high for this group (28%).
- Even among adults who work full-time for the full year, one in five remains uninsured.
- More than half (51%) of poor nonelderly adults are uninsured.
- Latinos are less likely than non-Latino whites to receive job-based coverage (45% versus 72%) regardless of how much they work, the size firm in which they work, or their educational attainment.
- Seven in 10 U.S.-born citizens had job-based insurance in 1999, compared to 64% of naturalized citizens, 46% of noncitizens who are legal residents, and 31% of undocumented immigrants.
- Opportunities for both employment-based health insurance and for Medi-Cal coverage also vary depending upon family composition.
  - One in three (32%) single adults is uninsured as a result of a moderate rate of job-based insurance (55%) and few opportunities for coverage through Medi-Cal (6%). Single adults account for half of the state's nonelderly adult uninsured population — a total of 2.5 million.
  - Just 16% of married couples without children are uninsured — half the rate for single adults. Married couples without children have higher rates of job-based insurance as a result of more opportunities to obtain dependent coverage.
  - Married couples with children also have substantial opportunities to be covered as a dependent, resulting in a relatively low uninsured rate.
  - Single parents have few opportunities to obtain job-based insurance as a dependent. Although their generally lower family incomes result in one in four depending upon Medi-Cal coverage, they still have a high rate of uninsurance (30%).
- We estimate that 685,000 nonelderly adults (range: 595,000 to 775,000) are uninsured but eligible for Medi-Cal coverage, about 14% of the nearly 5 million uninsured adults in the state. Many groups of adults have few options for receiving assistance to obtain coverage; this is particularly true for low-income single adults without children, those with no disabling condition, new legal immigrants, and the undocumented.

1 Reported numbers are estimates based on small sample sizes, which reduce the estimate's precision and reliability. The range (called, a "95% confidence interval") provides a more reliable estimate of the numbers of persons in the population who fit that category. It means that the "true" estimate has a 95% probability of falling within the range.

Latinos are far less likely to have job-based coverage, and they comprise 28% of the California population, compared to 11% nationally

EMPLOYMENT-BASED HEALTH INSURANCE COVERAGE

Job-based health insurance coverage rose both in California and nationally from 1994 to 1999, with particularly fast growth in California during the 1998-1999 period. Nevertheless, California still lags far behind the United States as a whole. One of the major reasons is that California employers are less likely to offer such coverage to their employees. Furthermore, although certain economically vulnerable subgroups in California have shown improvement over this time period, they still lag behind other groups in obtaining health insurance coverage from employment.

- The gap between California and the national average has lessened over time, but in 1999 Californians were still 6.6 percentage points less likely to receive health insurance through employers than the average American (62.8% vs. 69.4%).
- Whereas Californians overall have a 63% chance of obtaining job-based coverage, rates for particular groups are much lower. These include young adults age 19-24 (48%), Latinos (45%), non-citizens (40%), those without a high school degree (34%), those with low incomes (18% for those below the poverty line, and 43% for those between 100%-249% of poverty), part-time workers (55%), full-time workers employed part of the year (57%), and single parents (43%).
- To have coverage through one's own job, three things must take place: the employer must offer coverage, the employee must be eligible for it, and he or she must "take up" or enroll. Eligibility rates and take-up rates are roughly similar in California and in the United States as a whole, but offer rates are substantially lower in California. In 1999, 80.5% of California employees worked for an employer who offered health insurance coverage to at least some workers, compared to 85.6% of Americans. This 5.1% difference was somewhat lower than the 6.1% disparity five years earlier.

Further improvements in job-based coverage depend on continued economic growth as well as steady health insurance costs. If there is an economic downturn in California, or if there is a resurgence in health insurance premium inflation, recent gains will be jeopardized, since fewer employers would be able to afford to offer coverage, and fewer employees could afford to enroll.

- Already, the majority of families in many economically vulnerable California groups cannot afford the out-of-pocket premium costs of family coverage. For example, we calculate that 66% of uninsured Latinos would have to pay 5% or more of their income to afford employer-based family coverage, and 23% would have to pay 10% or more of their income. Given the other necessities of living, this is far beyond the means of most California residents.

THE GOAL IS UNIVERSAL COVERAGE

The state should fully fund the study mandated by SB 480 to analyze alternative approaches to achieve universal coverage, and it should adopt a state policy related to this goal.

Policy Recommendations

- Fully fund the study mandated by SB 480 to examine and identify cost-effective ways to extend health insurance coverage to all Californians.

California and the U.S. show similar trends over time in job-based coverage

- Enact a state policy committing California to achieve affordable health care coverage providing good access to quality care that enhances people's health.

Until the United States achieves universal coverage, it will be important to find ways to shore up the nation's eclectic arrangements of voluntary employment-based health insurance and public coverage programs.

EXPANDING EMPLOYMENT-RELATED HEALTH INSURANCE COVERAGE

The costs of health insurance and limited financial resources of most uninsured Californians and many employers underscore the necessity of providing financial assistance and other policies to expand health insurance coverage.

Policy Recommendations

- To help mid-sized firms offer affordable coverage, firms with up to 200 employees should be included in California's purchasing cooperatives.
- To encourage more employers to offer health benefits, both the federal government and the state of California could offer financial assistance to low-wage firms that provide and help pay for the costs of health insurance for their employees and spouses and dependent children.
- To help more workers accept health benefits for which they are eligible, the state of California should provide financial assistance for workers in low-income families to defray part of the costs of purchasing employer-based health insurance coverage.

EXPANDING PUBLIC PROGRAMS TO COVER UNINSURED CALIFORNIANS

The federal government has provided many opportunities for California to draw down federal matching dollars for a number of options to expand coverage for children and for their parents and some other adults.

The Governor's proposed expansion of Healthy Families could benefit up to 412,000 uninsured parents (range: 342,000 to 482,000) with income eligibility up to 200% of poverty. If the Governor raised income eligibility to 250% of poverty — the same as for children — 518,000 uninsured parents (range: 440,000 to 597,000) would be eligible for Healthy Families.

California could cover more uninsured children and their parents by raising Healthy Families' income eligibility to 300% of the poverty level.

Policy Recommendations

- Expand the Healthy Families Program eligibility to parents on the same eligibility basis as for their children.
- Increase income eligibility for the Healthy Families Program to 300% of the poverty guidelines.

ENHANCING ENROLLMENT OF ELIGIBLE PERSONS IN MEDI-CAL AND HEALTHY FAMILIES

The number of uninsured children and adults who are eligible for Medi-Cal or Healthy Families suggests that efforts to enroll eligible residents in these programs — and retain eligible beneficiaries once they are enrolled — ought to be enhanced. Although the state has improved its outreach and enrollment efforts, these efforts could be made more effective by several policy changes.

Economically disadvantaged Californians show the most improvement in coverage

Policy Recommendations

- The state should more fully engage community-based organizations, churches and schools in culturally sensitive outreach and expand funding for these efforts. Outreach should emphasize locally targeted media, use expanded federal authority and funds to enroll children in community settings away from the welfare office, and mobilize community leaders in these efforts.
- Fully implement Express Lane Eligibility to expedite enrollment in health programs for children who are participating in Food Stamps, the School Lunch Program, and WIC.
- Simplify the application and eligibility process for Medi-Cal and the Healthy Families Program by replacing income documentation with a "paperless" system used by many other states.
- Further simplify the application and eligibility process for Medi-Cal and the Healthy Families Program for children and adults by replacing the allowed expense deductions with an expanded income disregard as allowed under federal law.
- Reduce fragmentation for families by (1) integrating Medi-Cal and Healthy Families into a new program, or (2) creating an administrative overlay that retains separate program eligibility and funding but makes the programs seamless for enrollees, or (3) establishing a "bright line" between the programs so that all children and adults in a family are in the same coverage program.
- To avoid dumping eligible children out of Medi-Cal, vigorously implement the 12-month continuous eligibility for children, the elimination of the quarterly status report, and new procedures for retaining Medi-Cal for eligible persons when welfare ends.
- Take the eligibility determination process for California's public health care programs out of the welfare system.

3.7 MILLION ADULTS HAVE NO CURRENT OR PLANNED COVERAGE OPTIONS

At least 3.7 million uninsured adults would not qualify for Medi-Cal or the proposed expansion of Healthy Families. About seven in every 10 of these uninsured adults — a total of 2.6 million persons — are citizens or legal immigrants.

Policy Recommendations

- Apply for a section 1115 waiver to restructure the Medi-Cal and Healthy Families Programs to open them to people who do not meet traditional categorical requirements.
- The state of California should increase subsidies to MRMIP to expand opportunities for low-income persons who have been denied coverage in the private health insurance market.
- Local jurisdictions can mobilize community leadership, encourage or require contractors to offer health benefits to their employees, and generate local resources to expand coverage of their residents.
- Health care "safety net" providers will continue to need federal, state and local financial support to meet the needs of those who remain uninsured.

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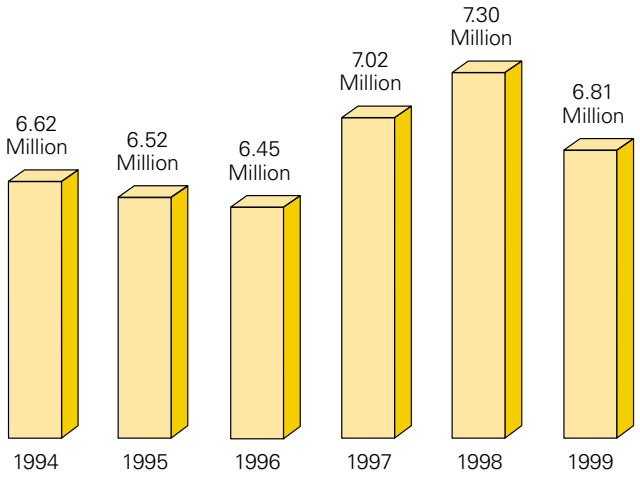
Jennifer Kincheloe, M.P.H., served as initial project manager, and assisted with the development of the eligibility simulation for public programs. Mary Richardson, Ph.D., also served as project manager and was assisted by Julia Prentice. Lucy Quacinella, J.D., provided extensive comments and suggestions as the health policy consultant for this report. Dan Gordon edited the final report.

introduction

The number of uninsured Californians dipped to 6.8 million in 1999, down from 7.3 million in 1998 (Exhibit 1). One in six of the nation's 42 million uninsured persons lives in California.

EXHIBIT 1. UNINSURED NONELDERLY CALIFORNIANS, AGES 0-64, CALIFORNIA, 1994 TO 1999



Source: March 1995, 1996, 1997, 1998, 1999, and 2000 Current Population Surveys

Despite the good news, more than one in five (22.4%) of the state's nonelderly residents have no health insurance coverage, about the same rate as in 1996, when California had not yet fully recovered from the recession of the early 1990s. This report provides information and analysis intended to help answer a series of policy questions:

- Does the most recent positive change represent a reversal of the previous long-term negative trend? How great an improvement does this represent? How long is it likely to last?
- Who has benefited from this improvement? Who continues to bear a disproportionate share of the risk of being uninsured?
- How does employment-based health insurance coverage in California differ from coverage nationally?
- What opportunities are there for uninsured children and adults to be covered through Medi-Cal and the Healthy Families Program?
- What public policies might stabilize or strengthen health insurance coverage?

The number of uninsured Californians dipped to 6.8 million in 1999, down from 7.3 million in 1998

The report examines the health insurance coverage of nonelderly Californians in 1999, as well as trends in coverage from 1994 to 1999. In Part 1, we provide an overview of the population's coverage. We look at coverage from a variety of sources and focus especially on the uninsured. In Part 2, we examine health insurance coverage of children, followed in Part 3 by an examination of coverage of adults. We look carefully at disparities in coverage — by race and ethnicity, citizenship and immigration status, age, family composition, and other factors. In these sections, we examine current opportunities for uninsured children and adults to obtain public coverage through Medi-Cal and the Healthy Families Program.[2] In Part 4, we dig deeper into access to employment-based health insurance, the primary source of coverage for most nonelderly adults and children, including disparities within California and differences between California and the nation as a whole. In this section, we also consider how trends in the recent past might inform our understanding of future trends — whether very recent improvements will turn into a trend. Finally, in Part 5, we look to the future and suggest policy options that would be most useful to enhance Californians' coverage and build a foundation for universal coverage.

The data used in this report are taken from several sources. Estimates of the health insurance coverage of the population are based on the March 1995, 1996, 1997, 1998, 1999, and 2000 Current Population Surveys, in which respondents were asked about coverage during the previous calendar year (i.e., 1994, 1995, 1996, 1997, 1998, and 1999, respectively). Estimates of working adults' access to health insurance through employment are based on the February 1995, 1997, and 1999 Current Population Surveys. In these surveys, employed respondents were asked a series of questions about whether, at the time of the survey (i.e., not the previous calendar year) their employer offers health insurance to any of their workers, whether the respondent is eligible for health benefits that are offered, and whether the respondent accepts health benefits when eligible.

All references in the text to differences in proportions between groups are statistically significant ($p \leq .05$) unless otherwise stated.

2 Medi-Cal is California's Medicaid program, a joint state and federal program that provides matching funds to states to cover families with children, disabled adults, and the elderly with income eligibility set by the states at or above a federal floor. The Healthy Families Program is California's version of the State Children's Health Insurance Program, which provides federal matching funds to states to cover children with family incomes above the limits for "no-share-of-cost" Medicaid.

Despite the recent decline, more than one in five of the state's nonelderly residents are uninsured

1. AN OVERVIEW OF HEALTH INSURANCE COVERAGE

1

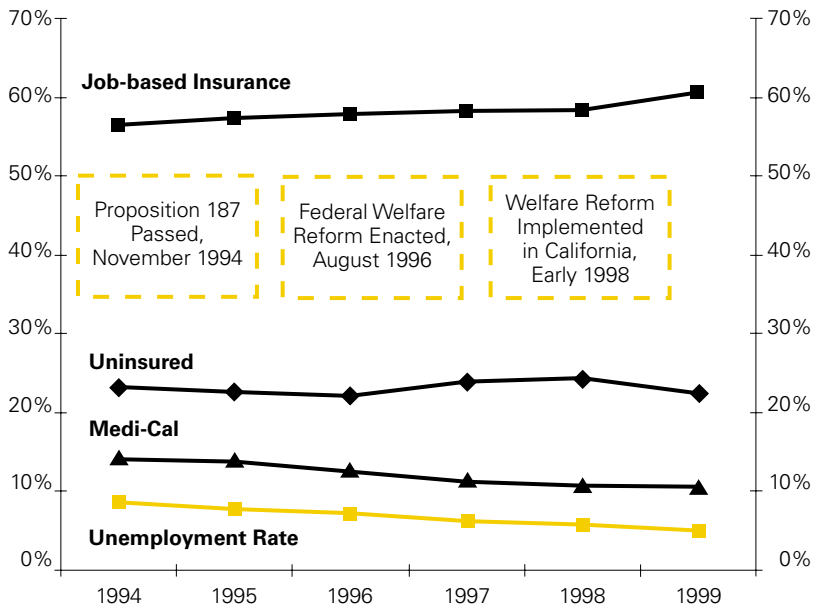
The drop in the number and proportion of Californians who are uninsured between 1998 and 1999 is due to new growth in employment-based health insurance coverage, aided by a slower decline in Medi-Cal coverage.

OVERVIEW IN CONTEXT

Employment-based insurance rose gradually from the intractable recession of the early 1990s, which was reflected in the low rate of job-based coverage in 1994 when unemployment was high (Exhibit 2). But job-based insurance rates did not visibly respond to the unprecedented period of economic growth until 1999. Meanwhile, Proposition 187 in 1994 and the enactment of federal welfare reform in 1996 engendered widespread fear among noncitizens, including legal permanent residents, that enrollment in public programs would jeopardize their immigration status. This fear preceded the actual implementation of welfare reform in California, but it discouraged participation in Medi-Cal. The combination of relatively flat or slow growth in employment-based coverage and falling Medi-Cal enrollment resulted in a persistent and rising rate of uninsurance, despite the booming economy.

In this part of the report, we examine health insurance coverage of the nonelderly population in more detail, including how it changed over time, who benefited from the change — and who did not.

EXHIBIT 2. HEALTH INSURANCE COVERAGE OF NONELDERLY CALIFORNIANS AND UNEMPLOYMENT RATE, AGES 0-64, CALIFORNIA, 1994-1999



Source: March 1995, 1996, 1997, 1998, 1999 and 2000 Current Population Surveys and California Employment Development Department, Labor Market Information

Until the most recent year, California experienced a persistent and rising rate of uninsurance despite the booming economy

EMPLOYMENT-BASED HEALTH INSURANCE

The proportion of nonelderly Californians who received health insurance through their own employment or that of a family member rose 2.3 percentage points between 1998 and 1999, from 58.3% to 60.6% — a greater increase in one year than in the four-year period from 1994 to 1998 (Exhibit 3).

This welcome improvement in health insurance coverage was a result of significant gains in employment, not an expansion of job-based coverage among working families. The proportion of nonelderly Californians in families in which no adult worked fell to its lowest level (9.7%) in six years, a strong gain that came only after several years of unparalleled economic growth. In 1999, the proportion whose families had at least one adult worker employed full time for the full year reached 66%, up from the 62%-63% level where it had hovered from 1995 (when California was beginning to emerge from the recession of the early 1990s) to 1998 (when the state was already well into the current economic boom). This is an important employment gain because full-time, full-year employees are the most likely to receive health benefits.

PRIVATELY PURCHASED HEALTH INSURANCE

Health insurance purchased in the nongroup market ("privately purchased") is an option for employees who do not obtain coverage through an employer and for self-employed adults — if they qualify and can afford it. Privately purchased insurance remained flat, covering 4.3% of nonelderly Californians in 1994 and 4.7% in 1999 (Exhibit 3).

EXHIBIT 3. HEALTH INSURANCE COVERAGE OF NONELDERLY CALIFORNIANS, AGES 0-64, CALIFORNIA, 1994, 1996, 1998, AND 1999

	1994	1996	1998	1999	CHANGE 1994-1999	CHANGE 1998-1999
UNINSURED	23.3%	22.3%	24.4%	22.4%	–0.9	–2.0*
JOB-BASED INSURANCE	56.4%	57.8%	58.3%	60.6%	+4.2*	+2.3*
PRIVATELY PURCHASED	4.3%	5.7%	4.5%	4.7%	+0.4	+0.2
MEDI-CAL/						
HEALTHY FAMILIES**	14.4%	12.8%	11.0%	10.5%	–3.9*	–0.5
OTHER PUBLIC	1.7%	1.5%	1.8%	1.7%	—	–0.1
TOTAL	100% (POPULATION: 28,370,000)	100% (POPULATION: 28,940,00)	100% (POPULATION: 29,870,000)	100% (POPULATION: 30,400,000)		

* Change is statistically significant at $p \leq .05$.

** Includes persons reporting enrollment in Medi-Cal (1994-1999) or the Healthy Families Program (1998-1999). Such estimates derived from surveys are generally lower than those derived from administrative data.

Note: Population estimate is based on March 2000 Current Population Survey, which may differ from population estimates derived from other sources.

Source: March 1995, 1997, 1999 and 2000 Current Population Surveys

The proportion of nonelderly Californians who received job-based insurance rose between 1998 and 1999

MEDI-CAL AND THE HEALTHY FAMILIES PROGRAM

For those who do not obtain coverage through employment and cannot purchase it privately, Medi-Cal (California's Medicaid program) or the Healthy Families Program (California's version of the State Children's Health Insurance Program, or CHIP) may be an option — but only for those who have low incomes and meet other stringent requirements. Medi-Cal is restricted to persons who fit into one of the program's eligibility categories. In addition, only persons in these groups whose family incomes and financial assets are low enough to meet the requirements specified for that group will be eligible. In general, only citizens and noncitizens legally residing in the United States are eligible for Medi-Cal,[3] but the noncitizens among this group have been further discouraged from enrolling in Medi-Cal. The implementation of some federal laws and California's Proposition 187, along with the debates over some provisions of federal welfare reform legislation, created an anti-immigrant climate.

Children may be eligible for Medi-Cal if their family incomes do not exceed specified limits (children are not subjected to an asset test), which vary depending on the age of the child. For infants under age 1, family income may not exceed 200% of the federal poverty guidelines; for children ages 1-5, up to 133% of poverty; and for children ages 6-18, up to 100% of poverty. Income deductions allowed for childcare and work expenses may enable children in families above the specified income level to be determined eligible for the program. Children who meet these requirements are eligible for no-share-of-cost Medi-Cal; that is, the child's family pays no premiums.

Children are eligible for the Healthy Families Program if their family income exceeds the Medi-Cal income eligibility level but does not exceed 250% of the poverty guidelines (after deducting allowed expenses). Unlike Medi-Cal, the Healthy Families Program, which was enacted in 1997 and began enrolling children in 1998, charges families modest premiums for health insurance coverage, ranging from $4 to $9 per month (up to $27 per family).

Adults may qualify for Medi-Cal if they are in a family with eligible children or are either a pregnant woman, a disabled nonelderly adult, an elderly adult (age 65 or over), or part of some other limited categories — and meet stringent income and asset limits set for the particular eligibility code under which they might qualify. Pregnant women may qualify for Medi-Cal with incomes up to 200% of poverty, and women with incomes between 200% and 300% of poverty are eligible for the Access for Infants and Mothers (AIM) Program. Those who are parents of Medi-Cal-eligible children may also be eligible if their family incomes do not exceed 100% of the poverty level, with a higher limit for those transitioning off of welfare. Adults without children may qualify for no-share-of-cost Medi-Cal if they are disabled and if their family incomes do not exceed 133% of poverty.[4] Other than these provisions, adults have few options for coverage through Medi-Cal.

The proportion of the nonelderly population that reported receiving Medi-Cal coverage tumbled from 14.4% in 1994 to 12.8% in 1996 (Exhibit 3). It continued to fall as the new Healthy Families Program was getting started — to 11.0% in 1998 despite a relatively flat rate of job-based insurance. Medi-Cal and Healthy Families coverage together

3 This includes PRUCOL aliens (those "permanently residing under color of law") who are eligible for full-scope Medi-Cal, but undocumented aliens not legally residing in the U.S. are eligible for pregnancy-related and emergency Medi-Cal.

4 For information on Medi-Cal eligibility, see Page C, Ruiz S, *The Guide to Medi-Cal Programs: A Description of Medi-Cal Programs, Aid Codes, and Eligibility Groups*, Oakland, CA: Medi-Cal Policy Institute, 1999.

dipped further to 10.5% in 1999, but this decline was offset by a larger increase in job-based coverage.[5] It should be noted that despite these continuing declines in Medi-Cal coverage based on CPS survey data, Medi-Cal enrollments based on administrative data have recently shown an increase. The administrative data indicate that California's Medi-Cal enrollments rose 1.3% from a low point in December 1997 to December 1999, although the end-of-1999 figure was still below the level earlier in 1997.[6]

The decline in Medi-Cal enrollment reported in the Current Population Survey between 1994 and 1996 may have been due, in part, to more people obtaining employment-based or other private health insurance, but most of the decline was due to changes in public policy, especially welfare reform, that occurred at the end of this period. First, welfare reform weakened the historical tie between Medi-Cal and federally funded public assistance programs. The Personal Responsibility and Work Opportunity Reconciliation Act of 1996 separated eligibility for Medi-Cal from eligibility for cash assistance to families with children.[7] Although families leaving welfare could remain eligible for transitional Medi-Cal, many were not informed of their eligibility and did not receive it.[8] Other low-income working families who had not received welfare were also potentially eligible but were not widely informed of this option. However, all these policy changes were not to take effect until 1998 in California, and even then many families were entitled to remain covered until a special review was conducted. But the enactment of these reforms and their anticipation created confusion about who was eligible, concern about lifetime eligibility for public assistance benefits, and fear among immigrants.

Welfare reform greatly restricted immigrant noncitizens' eligibility for public assistance — a change that disproportionately affected California residents. The federal legislation restricted Medicaid to citizens and to legal immigrants who were in the United States when welfare reform was signed (August 22, 1996). It also led to more widespread application of the "public charge" classification — as used by the State Department, 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, accounting for much of the drop in Medi-Cal coverage during the period 1996-1998. A modification of the policy issued by the Immigration and Naturalization Service (INS) in May 1999 and widely disseminated by community-based organizations may have eased these fears during the past year.

5 Persons identified in this report as covered by Medi-Cal or the Healthy Families Program are those who reported being covered by one of these programs (or were classified as such by the Current Population Survey) and who did not report having either employment-based health insurance or privately purchased insurance during the year. These estimates, as well as those of other surveys, are generally lower than estimates derived from the programs' administrative data. Note that only estimates for 1998 and 1999 include Healthy Families enrollees. See the Appendix for a fuller discussion of differences between estimates of Medi-Cal and Healthy Families enrollment based on administrative vs. survey data.

6 Ellis R, Smith VK, and Rousseau DM, *Medicaid Enrollment in 50 States, June 1997 to December 1999,* Washington, DC: Kaiser Commission on Medicaid and the Uninsured, October 2000.

7 Known nationally as Temporary Assistance for Needy Families, or TANF, and in California, as "CalWORKs."

8 Guyer J, *Health Care After Welfare: An Update of Findings from State-Level Leaver Studies*, Washington, DC: Center on Budget and Policy Priorities, 2000; Garrett B, Holahan J, "Health Insurance Coverage After Welfare," Health Affairs 2000; 19(1): 175-184. Although the majority of women who left welfare were working, only 33 percent of these women obtained health coverage through their jobs. Rates of uninsurance increased with the number of months since leaving welfare and with declines in Medicaid coverage. A year or more after leaving welfare, 49 percent of women and 30 percent of children were uninsured.

The proportion of persons covered by Medi-Cal fell between 1994 and 1999

The combination of welfare reform's limits on receipt of public assistance and added restrictions on immigrants pushed many recipients into entry-level jobs that paid low wages and did not offer health benefits. Additionally, for many potential Medi-Cal recipients the stigma of the welfare office interview, required for eligibility determination, has kept them from seeking Medi-Cal coverage even when they are eligible.[9]

THE UNINSURED

The uninsured rate in 1994 (23.3%) appeared to decline slightly (but not significantly) by 1996 (22.3%) as the state's economy began to recover from the recession (Exhibit 3). It then climbed to 24.4% in 1998 following the enactment and implementation of welfare reform. It finally fell back to 22.4% in 1999 as economic gains brought improved employment, especially for those who previously had been unemployed or not in the labor force. It is noteworthy that this lower uninsured rate is higher than it was early in the economic recovery.

HEALTH INSURANCE COVERAGE IN CALIFORNIA COMPARED TO THE NATIONAL AVERAGE

Compared to the United States as a whole, California's nonelderly population has lower rates of job-based insurance and higher uninsured rates.[10] This is true in spite of the fact that employer-sponsored health insurance is less expensive in California, and that employees foot a lower portion of the premiums. In 1999, California had a significantly higher uninsured rate than the nation as a whole (22.4% in California vs. 17.4% nationally, Exhibit 4) — although the difference has declined somewhat since 1994. If California had the same uninsured rate as the national average, it would have only 5.3 million uninsured residents — 1.5 million fewer than it has.

This higher rate of uninsurance was largely driven by California's lower rate of employment-based coverage (60.6% vs. 68.1%).

California's uninsured rate would be even higher if the state's Medi-Cal income eligibility policies were less generous. In California in 1999, even after several years of decline, 10.5% of the nonelderly population obtained coverage through Medi-Cal or the Healthy Families Program, compared with only 8.0% in the United States overall.[11] If California covered only the national average in its Medi-Cal and Healthy Families programs and if these residents had no other health insurance alternative — which is likely for most enrollees — it would have 7.6 million uninsured residents, 768,000 more than it has.

Among the 50 states and the District of Columbia, California has the second lowest proportion of nonelderly residents with job-based insurance coverage exceeded by New

9 Perry MJ, Stark E, Valdez RB, *Barriers to Medi-Cal Enrollment and Ideas for Improving Enrollment: Findings from Eight Focus Groups in California with Parents of Potentially Eligible Children*, Menlo Park, CA: Henry J. Kaiser Family Foundation, 1998.

10 Throughout this report we compare health insurance coverage in California to coverage in the United States as a whole. An alternative would have been to compare California to the average of all other states. We chose the former method because the national average is easier to comprehend than the average for all other states, and it facilitates comparison to other data sources. It is important to note, however, that including California in the U.S. figures reduces any differences reported between California and the nation as a whole. Thus, any such differences reported are on the conservative side.

11 As noted above, Medicaid estimates derived from surveys are generally lower than those derived from administrative data.

The proportion who are uninsured declined in 1999 but it was still no lower than in 1996

Mexico and tied for second lowest with seven other states. This low rate accounts for the state having the fourth highest uninsured rate (exceeded by New Mexico, Texas, and Louisiana, and tied for fourth highest with Arizona, Florida, Nevada, and Idaho).

Californians have had higher uninsured rates than the U.S. average for at least two decades. However, the 1999 gap of 5.0 percentage points is narrower than in 1994, when California's uninsured rate (23.3%) was 6.1 percentage points higher than the nation's as a whole (17.2%). This improvement is due to California's expanding employment-based health insurance; the current 7.5 percentage-point gap in that category is narrower than the 9.2 percentage-point difference (56.4% vs. 65.6%) in 1994.

It is noteworthy that during this same period, Medi-Cal coverage declined more rapidly in California than did Medicaid coverage nationally. In the United States as a whole, nonelderly residents' Medicaid coverage fell 1.8 percentage points between 1994 and 1999 (from 9.8% to 8.0%), while in California, Medi-Cal coverage fell 3.9 percentage points (from 14.4% to 10.5%). (Administrative data show less of a decline; for a discussion of the reasons for differences between estimates of Medi-Cal coverage from population-based surveys and those from administrative data, see the Appendix.)

EXHIBIT 4. HEALTH INSURANCE COVERAGE OF NONELDERLY PERSONS, AGES 0-64, CALIFORNIA AND U.S., 1994 AND 1999

	CALIFORNIA		U.S.	
	1994	1999	1994	1999
UNINSURED	23.3%	22.4%	17.2%	17.4%
JOB-BASED INSURANCE	56.4%	60.6%	65.6%	68.1%
PRIVATELY PURCHASED	4.3%	4.7%	5.0%	4.3%
MEDI-CAL/ HEALTHY FAMILIES*	14.4%	10.5%	9.8%	8.0%
OTHER PUBLIC	1.7%	1.7%	2.4%	2.3%
TOTAL	100%	100%	100%	100%

* Includes persons reporting enrollment in Medi-Cal or the Healthy Families Program in California, and in Medicaid or the State Children's Health Insurance Program nationally. Such estimates derived from surveys are generally lower than those derived from administrative data.

Source: March 1995 and 2000 Current Population Surveys

Californians are persistently disadvantaged in their health insurance coverage, driven by a low rate of job-based insurance

UNINSURED CALIFORNIANS ARE LOW-AND MODERATE-INCOME WORKING FAMILIES

Well over eight in 10 (85%) of the uninsured are workers and their spouses and children (Exhibit 5) — for a total of 5.8 million uninsured Californians in working families. Half (51%) are in families headed by at least one employee who works full time all year round — a total of 3.5 million uninsured full-time, full-year employees and their family members.

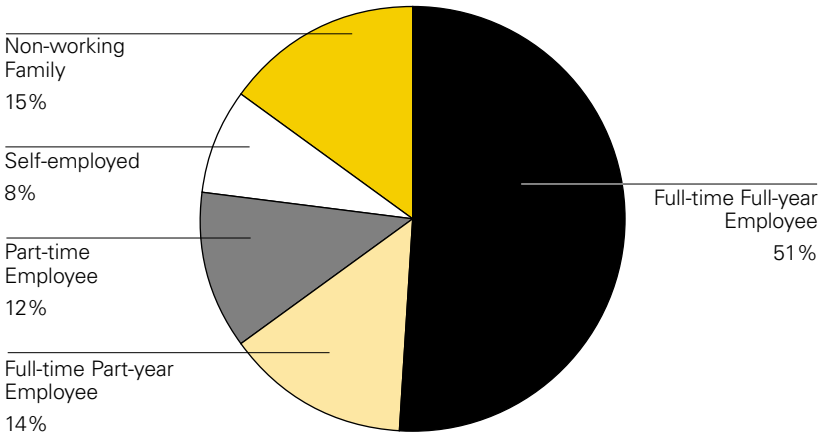
Many of these adults and children are in working families whose breadwinners do not have access to employment-based health insurance. As we will see in Part 4 of this report, this can be because their employer does not offer health benefits to any of its workers or because the employee is not eligible under the employer's rules. In other cases, individuals work for employers that do offer health benefits, but the employee finds the required premium contribution unaffordable.

FAMILY INCOMES OF UNINSURED CALIFORNIANS

The uninsured are a disproportionately low-income group — a characteristic with important implications for efforts to expand coverage. Among California's uninsured population, one-fourth (26%) had incomes below the federal poverty level and another 41% had family incomes between 100% and 249% of the federal poverty level in 1999 (Exhibit 6).[12] Thus, two-thirds of the uninsured have family incomes so low that they are unlikely to be able to afford any substantial contribution toward the costs of health insurance premiums. To make health insurance affordable for them, an employer or the government will need to pay most, if not all, of the cost. Only 17% of the uninsured had family incomes four times the poverty threshold or greater.

This distribution of the uninsured by family income is quite different from the income distribution of the state's nonelderly population — underscoring the higher risk of being uninsured among low- and moderate-income

EXHIBIT 5. UNINSURED NONELDERLY PERSONS BY FAMILY WORK STATUS, AGES 0-64, CALIFORNIA, 1999



12 In 1999, the poverty threshold was $8,667 for one person under age 65, $11,214 for a family of two under age 65, $13,290 for a family of three, and $17,029 for a family of four, etc.

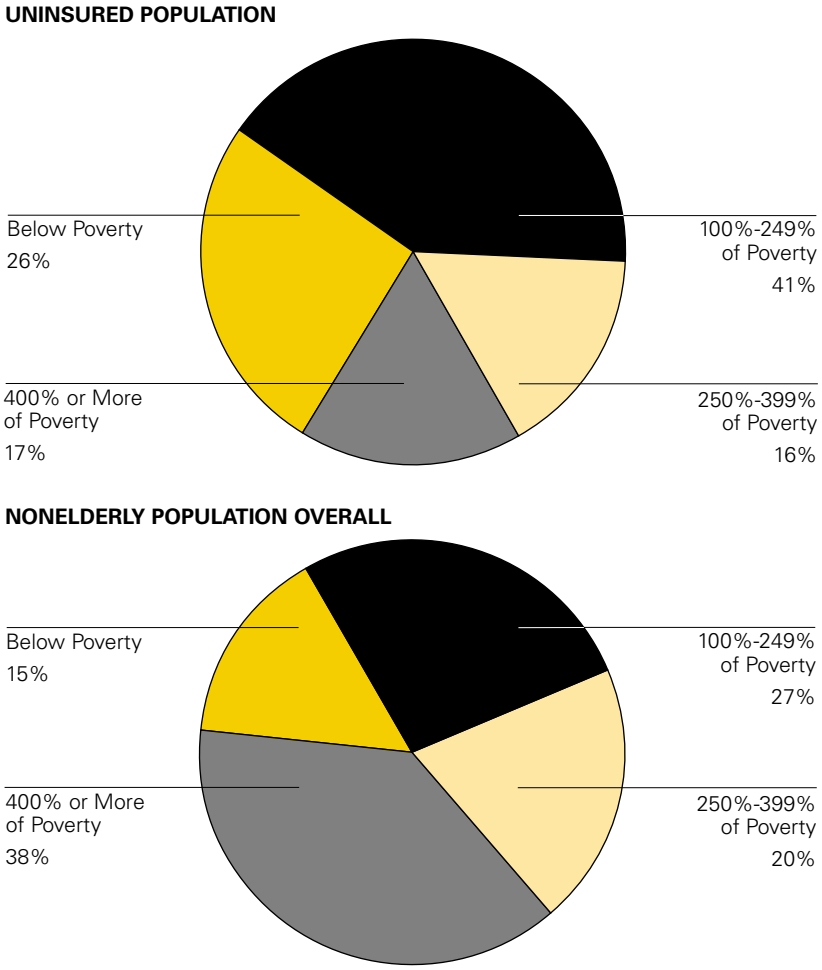
Source: March 2000 Current Population Survey

Over eight in 10 of the uninsured are workers and their family members

persons. In 1999, 15% of nonelderly residents were poor, compared to 26% of the uninsured (Exhibit 6). Another 27% of the population was near poor, compared to 41% of the uninsured. On the other hand, 38% of nonelderly residents had incomes of at least 400% of the poverty level, compared to just 17% of the uninsured.

Children and nonelderly adults with family incomes below poverty experienced a sharp increase in their uninsured rate between 1994 and 1999. This is the only income group in California whose uninsured rate grew during this period. The percentage of poor residents who are uninsured appeared to rise in California from 38% to 40% (not a statistically significant increase), while nationally it

EXHIBIT 6. DISTRIBUTIONS OF UNINSURED AND NONELDERLY CALIFORNIANS OVERALL BY POVERTY LEVEL, AGES 0-64, CALIFORNIA, 1999



Source: March 2000 Current Population Survey

Two-thirds of the uninsured have very low family incomes

climbed from 31% to 35%. This apparent growth in uninsurance is particularly disconcerting because these very low-income adults and children experienced increased employment-based insurance coverage during this period: from 12% to 18% in California, and from 18% to 21% nationally.

For this poverty population, falling Medicaid coverage was responsible for their rising uninsured rate. In California, Medicaid coverage fell 8 percentage points (from 46% of poor children and adults in 1994 to 38% in 1999), while nationally Medicaid coverage fell 7 percentage points (from 43% to 36%).

ETHNIC AND RACIAL DIFFERENCES IN HEALTH INSURANCE COVERAGE

Latinos continue to have the lowest health insurance coverage of any ethnic group. Just 43% of Latinos had employment-based coverage in 1999, compared with 72% of non-Latino whites (Exhibit 7). Both groups' rates were up from 1998, when 40% of Latinos and 70% of non-Latino whites ("whites") had job-based insurance.

Latinos' low rate of job-based coverage is partially offset by Medi-Cal, although Medi-Cal covered 17% of Latinos in 1999 (and 1998), far lower than in 1994 (22%). Latinos' rise in job-based insurance between 1994 and 1999, together with a slight increase in privately purchased insurance, offset the erosion in Medi-Cal coverage. As a result, 36% of Latinos remained uninsured in 1999 (the same as in 1994), compared to 13% of whites (3 percentage points lower than in 1994).

Asian Americans and Pacific Islanders (AAPIs) also have a lower rate of job-based insurance than do whites, but their rate in 1999 (63%) reflects a fairly steady improvement over 1994 (52%). But between 1994 and 1999, AAPIs' Medi-Cal coverage fell from 18% to 7%, equal to the rise in job-based coverage; this left 22% uninsured in 1999, the same as in 1994.

African Americans gained from the economic growth in the latter 1990s, with their job-based coverage climbing from 52% in 1994 to 59% in 1999 — a rate still far below that of whites. As with other ethnic groups, falling Medi-Cal coverage, from 24% in 1994 to 15% in 1999, left 22% still uninsured in 1999.

American Indians and Alaska Natives (AI/ANs) also have a very low rate of employment-based health insurance, just 53% in 1997-1999. Medi-Cal only partially offsets this low rate of job-based coverage, leaving 20% of AI/ANs uninsured. (The small number of American Indians and Alaska Natives in the California sample of the Current Population Survey necessitated our using three-year averages for their estimates.)

The United States government has a trust responsibility to provide health care to American Indians and Alaska Natives who are members of federally recognized tribes.[13] To obtain Indian Health Service care, the individual would have to travel to his or her home reservation. While 554 tribes are currently recognized by the federal government, other tribes are recognized solely by their home states or are "self-recognized" and not recognized by the federal government, leaving their members ineligible for IHS

13 The relationship between the federal government and American Indian and Alaska Native people is based on treaty obligations, case law, the Snyder Act of 1921 (PL 83-568), the Indian Health Care Improvement Act (PL 94-437), and other public policies. (Pevar SL, *The Rights of Indians and Tribes: The Basic ACLU Guide to Indian and Tribal Rights*, 2nd ed. Carbondale, IL. Southern Illinois University Press, 1992).

EXHIBIT 7. HEALTH INSURANCE COVERAGE OF NONELDERLY PERSONS BY ETHNIC GROUP, AGES 0-64, CALIFORNIA, 1994 AND 1999

	1994	1999
UNINSURED		
NON-LATINO WHITE	16%	13%
LATINO	36%	36%
ASIAN AMERICAN/PACIFIC ISLANDER	22%	23%
AFRICAN AMERICAN	20%	22%
AMERICAN INDIAN/ALASKA NATIVE*	—	20%
JOB-BASED INSURANCE		
NON-LATINO WHITE	69%	72%
LATINO	39%	43%
ASIAN AMERICAN/PACIFIC ISLANDER	52%	63%
AFRICAN AMERICAN	52%	59%
AMERICAN INDIAN/ALASKA NATIVE*	—	53%
PRIVATELY PURCHASED		
NON-LATINO WHITE	6%	7%
LATINO	1%	2%
ASIAN AMERICAN/PACIFIC ISLANDER	5%	5%
AFRICAN AMERICAN	2%	2%
AMERICAN INDIAN/ALASKA NATIVE*	—	2%
MEDI-CAL/HEALTHY FAMILIES**		
NON-LATINO WHITE	7%	6%
LATINO	22%	17%
ASIAN AMERICAN/PACIFIC ISLANDER	18%	7%
AFRICAN AMERICAN	24%	15%
AMERICAN INDIAN/ALASKA NATIVE*	—	20%

* Estimates for American Indians/Alaska Natives are three-year averages reflecting coverage in 1997-1999 because they are averages of the March 1998, 1999, and 2000 Current Population Surveys. These are more stable than one-year estimates.

** Includes persons reporting enrollment in Medi-Cal (1994 and 1999) or the Healthy Families Program (1999). Such estimates derived from surveys are generally lower than those derived from administrative data.

Source: March 1995 and 2000 Current Population Surveys

Despite increases in job-based insurance coverage, there was no improvement in the uninsured rates for people of color

services.[14] In California, there are an estimated 292,000 AI/ANs and 105 federally recognized tribes, whose members are eligible for health care services — but only from their own tribe's facilities. Another 40 tribes in California are state-recognized, but not federally recognized, and their members are thus ineligible for services, with some exceptions.[15]

IHS services are usually located on or near reservations and thus are not very accessible to urban Indians who constitute a majority of the AI/AN population. The limited resources of programs serving urban Indians are reflected in the absence of even a single AI/AN health clinic in Los Angeles County, the urban area with the greatest number of AI/ANs.[16] The very restricted access to health care of many Indians who are officially eligible for services is sufficient reason not to count IHS eligibility as a type of health insurance coverage.[17]

ASIAN AMERICAN AND PACIFIC ISLANDER SUBGROUPS

Aggregate health insurance statistics for the Asian American and Pacific Islander (AAPI) groups mask the heterogeneity across AAPI subgroups. Exhibit 8, which presents information on coverage for 10 AAPIs subgroups, [18] demonstrates this heterogeneity. Third-plus generation AAPIs, who are more acculturated and more integrated into the U.S. labor and health insurance markets, have higher rates of job-based coverage and lower rates of uninsurance. Filipinos, Japanese and South Asians also exhibit this health insurance advantage, related to higher levels of educational attainment.

Southeast Asians also have a lower uninsured rate (19%) than the aggregate AAPI category, but they have abysmally low job-based coverage (34%) that is augmented by very high Medi-Cal participation. Vietnamese, like most other Southeast Asians (Cambodians, Lao, Hmongs, and Mien), have refugee status that gives them greater access to Medi-Cal, although growing labor force participation, in part, has reduced their Medi-Cal participation rate to 17%, a much lower rate than the Southeast Asian group. Yet the rise in Vietnamese employment-based health insurance has not offset the drop in Medi-Cal coverage and therefore puts this group at higher risk of being uninsured than the AAPI group as a whole.

The uninsured rates for those originating from China, Hong Kong, Taiwan and Singapore are also higher than the average AAPI group. The most at-risk group for being uninsured is the Korean subgroup (45%), whose rate is even higher than that of Latinos. High rates of self-employment and employment in small firms continue to limit Koreans' access to job-based insurance.

14 Department of the Interior, Bureau of Indian Affairs.

15 Information generously provided by Delight Satter, Program Manager, American Indian and Alaska Native Program, UCLA Center for Health Policy Research, December 21, 2000. The small sample size for American Indians/Alaska Natives in the California sample of the CPS makes it statistically infeasible to generate an estimate of eligibility for IHS services — a problem that should be ameliorated when data from the California Health Interview Survey are available late in 2001.

16 Information generously provided by Delight Satter, Program Manager, American Indian and Alaska Native Program, UCLA Center for Health Policy Research, December 21, 2000.

17 Beginning in 1998, the U.S. Census Bureau ceased counting IHS eligibility as health insurance coverage.

18 The CPS collects, but does not report, national subgroups for AAPIs. We developed a proxy ethnic classification of AAPIs into ethnic subgroups based on the birthplace of the AAPI respondent or his/her parents. If both parents were U.S.-born, we labeled these individuals as "third-generation AAPI." All others were assigned to Filipino, Chinese (China, Hong Kong, Taiwan, Singapore), Japanese, Korean, Vietnamese, South East Asian (Cambodia, Laos), South Asian (India, Pakistan, Bangladesh), Pacific Islanders, and Other AAPI.

There are large differences in health insurance coverage across Asian American and Pacific Islander subgroups

There were too few observations of Pacific Islanders in the CPS sample to provide an estimate for uninsurance. We do, however, estimate that only 55% of Pacific Islanders (which includes Native Hawaiians) are covered through their own or a family member's employment-based insurance. This rate is lower than the AAPI group as a whole, whites and African Americans.

The "Other AAPI" category encompasses a group with a high uninsured rate (36%) and low job-based coverage (45%). This group includes individuals from all other countries, notably those from Thailand, one of the fastest growing AAPI communities in California.

Finally, we urge caution in interpreting these subgroup estimates because they approximate AAPI ethnic subgroups. Our place-of-birth proxy method for ethnicity has limitations that cannot disentangle the diaspora of ethnic groups across Asia (which is considerable among the Chinese and Indians), and cannot differentiate the ethnicity of third-generation AAPIs. Although this approach has limitations, until CPS releases codes for these ethnic subgroups, it is the only alternative to detect disparities that may be missed within this aggregate AAPI group.

EXHIBIT 8. HEALTH INSURANCE COVERAGE OF NONELDERLY PERSONS BY ASIAN AMERICAN AND PACIFIC ISLANDER ETHNIC SUBGROUP, AGES 0-64, CALIFORNIA, 1997-1999 (3-YEAR AVERAGE)*

	UNINSURED	JOB-BASED INSURANCE	PRIVATELY PURCHASED	MEDI-CAL
AAPI OVERALL[1]	23%	63%	5%	7%
THIRD-PLUS GENERATION AAPIs	15%	68%	5%	9%
FILIPINO[2]	16%	72%	4%	3%
CHINESE[2]	28%	60%	9%	**
JAPANESE[2]	18%	71%	**	**
KOREAN[2]	45%	40%	13%	**
VIETNAMESE[2]	29%	48%	4%	17%
SOUTHEAST ASIAN[2]	19%	34%	**	45%
SOUTH ASIAN[2]	15%	73%	8%	**
PACIFIC ISLANDERS[2]	**	55%	**	**
OTHER AAPI[2]	36%	45%	3%	15%

1 March 2000 Current Population Survey estimates for 1999.

2 First- and second-generation immigrants

* Estimates for Asian American and Pacific Islander subgroups are three-year averages reflecting coverage in 1997-1999 because they are based on averages of the March 1998, 1999, and 2000 Current Population Surveys. These are more stable than one-year estimates.

** Estimates are not statistically reliable.

Source: March 1998, 1999 and 2000 Current Population Surveys

DIFFERENCES ACROSS COUNTIES

Counties are responsible, under the state's Welfare and Institutions Code section 17000, for meeting the health care needs of their low-income uninsured residents. They, therefore, have a strong interest in knowing their residents' health insurance status and how their coverage compares to that of other counties. County-level data on health insurance coverage are, however, very limited. In Exhibit 9, we present estimates of uninsurance and job-based coverage by region and for each county or group of counties. The prospects for receiving employment-based health insurance coverage and the risk of being uninsured are not evenly spread across the state. Counties with high uninsured rates have low rates of employment-based health insurance, reflecting regional differences in industry, occupations, and workforce characteristics. To capture one dimension of workforce characteristics, we supplement our health insurance data in Exhibit 9 with a three-year average of unemployment rates at the county level.

Like health insurance coverage, employment opportunities, a prime indicator of economic prosperity, vary widely throughout California. In general, Southern California counties have the highest unemployment and uninsured rates, with the exception of Ventura County, which has a relatively lower uninsurance rate (Exhibit 9). In contrast, the Bay Area and Sacramento tend to have low unemployment rates and low uninsurance rates — except for San Francisco, which has a high uninsured rate and a low unemployment rate. High unemployment rates and medium to high uninsured rates characterize the Central Valley counties. Northern counties do not fall into such clear patterns.

Due to limitations of the data, we can present only 6 county groups (including Los Angeles and "all others") and 22 counties, out of California's 58 counties. Moreover, while the regional rates are one-year estimates, for the county-level rates we average three years of data to increase the precision of the estimates. It is important to note that the range estimates give a more reliable picture of coverage in each locale. For example, while San Francisco has the highest estimated uninsurance rate (34%), this ranges from 29% to 38%, a much wider range than the Los Angeles uninsurance rate (32%, ranging from 31%-33%). Hence, particularly for the smaller counties, interpretation of our estimates should consider both rates and ranges. More precise county-level health insurance coverage rates will be available when data from the California Health Interview Survey (CHIS) are released toward the end of 2001.

This section provided an overview of the health insurance of California's non-elderly population, how it compares with the U.S. and how it has changed recently and since 1994. Our discussion centered on the uninsured, as we identified vulnerable groups and regions with high uninsured rates and low-job-based health insurance. The following sections delve deeper into the issues as we focus on the state of health insurance for specific groups: coverage of children and their eligibility for Medi-Cal and Healthy Families in Part 2; coverage of nonelderly adults and their eligibility for Medi-Cal in Part 3; and employment-based health insurance for workers and their families in Part 4. Finally, in Part 5, we offer policy recommendations for the state to expand and improve coverage options for California's 6.8 million uninsured residents.

The prospects for receiving job-based insurance and the risk of being uninsured are not evenly spread across counties

EXHIBIT 9. UNINSURED AND JOB-BASED INSURANCE RATES OF NONELDERY PERSONS BY COUNTY OF RESIDENCE, AGES 0-64, CALIFORNIA, 1997-1999 (3-YEAR AVERAGE)

	UNINSURED[1]		JOB-BASED INSURANCE[1]		UNEMPLOYMENT	POPULATION AGES 0-64
COUNTY/COUNTY GROUP[5]	**RATE**	**RANGE[2]**	**RATE**	**RANGE[2]**	**RATE[3]**	**1998[4]**
NORTHERN CALIFORNIA[6, 7]	16%		62%		—	—
BUTTE	27%	21%-32%	44%	38%-50%	7.9%	163,291
PLACER	13%	6%-20%	70%	60%-79%	3.9%	195,629
SACRAMENTO	16%	13%-19%	61%	58%-65%	4.9%	1,046,539
YUBA, SUTTER	29%	23%-34%	47%	41%-53%	13.9%	120,930
GREATER BAY AREA[7]	17%		72%		—	—
ALAMEDA	17%	14%-20%	72%	69%-76%	4.0%	1,278,919
CONTRA COSTA	11%	8%-13%	82%	78%-85%	3.6%	810,069
MARIN	13%	7%-19%	68%	60%-76%	2.4%	211,358
MONTEREY	29%	22%-36%	45%	37%-52%	10.3%	345,290
NAPA, SOLANO	10%	7%-14%	71%	65%-76%	5.2%	455,159
SAN FRANCISCO	34%	29%-38%	53%	48%-59%	3.6%	671,705
SAN MATEO	15%	11%-19%	75%	70%-79%	2.4%	628,829
SANTA CLARA	16%	14%-18%	72%	69%-75%	3.1%	1,540,921
SONOMA	17%	11%-22%	75%	69%-81%	3.2%	382,796
CENTRAL VALLEY[7]	19%		56%		—	—
FRESNO, MADERA	18%	15%-22%	54%	50%-59%	13.5%	805,703
MERCED	22%	16%-27%	50%	43%-56%	14.6%	185,309
STANISLAUS	17%	13%-22%	58%	52%-64%	11.9%	385,273
SAN JOAQUIN	22%	17%-26%	60%	53%-67%	10.0%	489,138
TULARE	26%	20%-31%	43%	37%-49%	15.8%	323,671
SOUTHERN CALIFORNIA[7, 8]	21%		63%		—	—
RIVERSIDE, SAN BERNARDINO	23%	21%-25%	58%	56%-61%	6.0%	2,763,336
KERN	23%	18%-27%	60%	55%-65%	11.9%	573,562
ORANGE	23%	21%-25%	64%	62%-67%	2.9%	2,500,853
SAN DIEGO	22%	20%-24%	56%	52%-61%	3.6%	2,518,119
SAN LUIS OBISPO	21%	15%-27%	60%	57%-62%	4.0%	202,181
SANTA BARBARA	26%	21%-32%	64%	58%-70%	4.4%	355,022
VENTURA	16%	12%-20%	73%	68%-77%	5.6%	663,161
LOS ANGELES	32%	31%-33%	50%	49%-52%	6.4%	8,716,230
ALL OTHER COUNTIES[7]	11%		52%		—	—

Source: March 1998, 1999 and 2000 Current Population Surveys

1 These estimates of health insurance coverage are three-year averages, which are more stable than one-year estimates.

2 Reported rates are estimates. The true rate is likely to fall in this range (95% confidence interval). Estimates for regions are more precise.

3 The unemployment rates are three-year averages computed from data published by the California Employment Development Department, Labor Market Information Division, Information Services Group. These rates are not seasonally adjusted.

4 The population numbers are California State Department of Finance estimates for each county for January 1, 1998.

5 Counties not shown fall into two categories: (1) the county was not sampled in the March Current Population Survey (CPS) — for example Santa Cruz county; (2) estimates for both the uninsured and job-based insurance rates were not statistically stable. Additionally, county groups displayed in the exhibit reflect CPS sampling of the area — for example Riverside, San Bernardino.

6 The Northern California rate includes El Dorado and Yolo counties, but these counties are not shown because of unstable rates.

7 Regional rates are one-year estimates for 1999, data source March CPS 2000.

8 The Southern California rate excludes Los Angeles county.

2. CALIFORNIA'S CHILDREN: HIGH UNINSURED RATES, RECENT IMPROVEMENTS AND OPPORTUNITIES FOR EXPANDED COVERAGE

2

A total of 1.85 million of California's children have no private or public health care coverage of any kind — more than one in six of the nation's 10.7 million uninsured children. This large number of uninsured children in California is an improvement over 1998, when more than 2 million were uninsured.

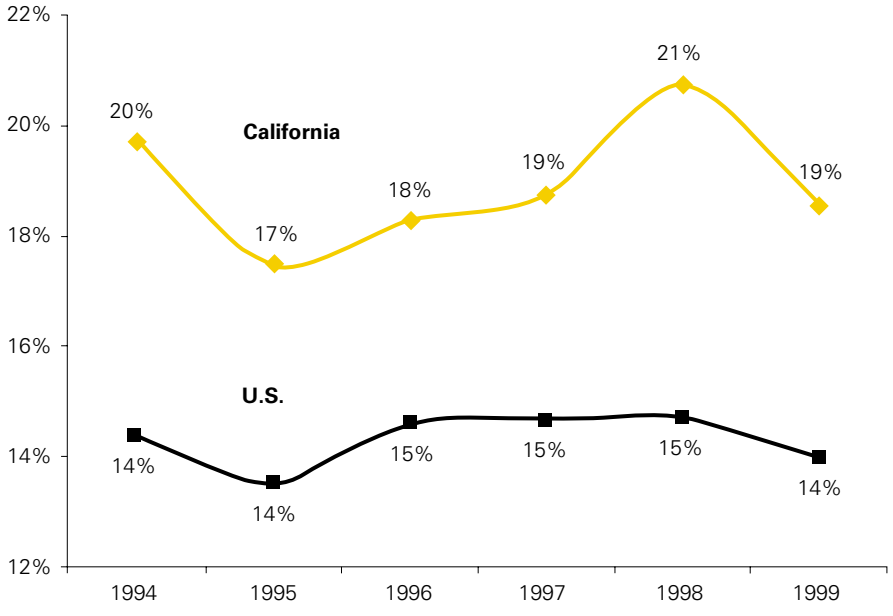
CALIFORNIA'S CHILDREN ARE AT HIGHER RISK OF BEING UNINSURED

One in five California children is uninsured, a larger proportion than in the United States as a whole. In 1999, 19% of the state's children up to age 18 were uninsured, compared to 14% nationally (Exhibit 10). If California's children were uninsured at the same rate as the national average, only 1.39 million children would be uninsured — 457,000 fewer.

This disadvantage for California's children has persisted throughout the 1990s. The uninsured rate in 1999 was lower than in 1998 when 21% of California's children were uninsured — a peak uninsured rate that reflected the enactment and implementation of welfare reform. However, the lower rate in 1999 was still higher than in 1995 when the state was climbing out of the recession, which had produced an especially high uninsured rate for children in 1994.

California children's higher rate of uninsurance is due to their lower rate of health insurance coverage obtained through a parent's employment: 56% in California

EXHIBIT 10. PERCENT OF CHILDREN WHO ARE UNINSURED, AGES 0-18, CALIFORNIA AND U.S., 1994 TO 1999



Source: March 1995, 1996, 1997, 1998, 1999 and 2000 Current Population Surveys

One in five California children is uninsured, a larger proportion than in the United States as a whole

EXHIBIT 11. HEALTH INSURANCE COVERAGE OF CHILDREN, CALIFORNIA AND U.S., AGES 0-18, 1999

	CALIFORNIA	U.S.
UNINSURED	19%	14%
JOB-BASED INSURANCE	56%	65%
PRIVATELY PURCHASED	4%	4%
MEDI-CAL/HEALTHY FAMILIES AND MEDICAID/CHIP*	19%	15%
OTHER PUBLIC	2%	2%
TOTAL	100% (POPULATION: 9,961,000)	100% (POPULATION: 76,330,000)

* Includes persons reporting enrollment in Medi-Cal or the Healthy Families Program in California and in Medicaid or the State Children's Health Insurance Program nationally. Such estimates derived from surveys are generally lower than those derived from administrative data.

Note: Numbers may not add to 100% due to rounding. Population estimate is based on March 2000 Current Population Survey, which may differ from population estimates derived from other sources.

Source: March 2000 Current Population Survey

compared to 65% in the nation as a whole (Exhibit 11). The state's Medi-Cal and Healthy Families programs have more generous income eligibility than those in many states (although not as generous as some), but they only partially offset California's lower rate of employment-based insurance for children.

Children's health insurance obtained through a parent's employment has hovered around 54% to 56% from 1996 through 1999, an improvement over the low recession-related rate in 1994 (Exhibit 12). However, between 1994 and 1999 Medi-Cal coverage plummeted from 25% to 19%, a direct result of the enactment and implementation of welfare reform.

EXHIBIT 12. HEALTH INSURANCE COVERAGE OF CHILDREN, AGES 0-18, CALIFORNIA, 1994-1999

	1994	1995	1996	1997	1998	1999	CHANGE 1994-1999
UNINSURED	20%	17%	18%	19%	21%	19%	–1
JOB-BASED INSURANCE	50%	53%	54%	56%	54%	56%	+6*
PRIVATELY PURCHASED	3%	3%	4%	3%	4%	4%	+1*
MEDI-CAL/ HEALTHY FAMILIES**	25%	25%	22%	21%	20%	19%	–6*
OTHER PUBLIC	2%	1%	1%	2%	2%	2%	—
TOTAL	100%	100%	100%	100%	100%	100%	

* Change is statistically significant at $p \leq .05$.

** Includes persons reporting enrollment in Medi-Cal (1994-1999) or the Healthy Families Program (1998 and 1999). Such estimates derived from surveys are generally lower than those derived from administrative data.

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

Source: March 1995, 1996, 1997, 1998, 1999 and 2000 Current Population Surveys

Children's health insurance has improved slightly in California

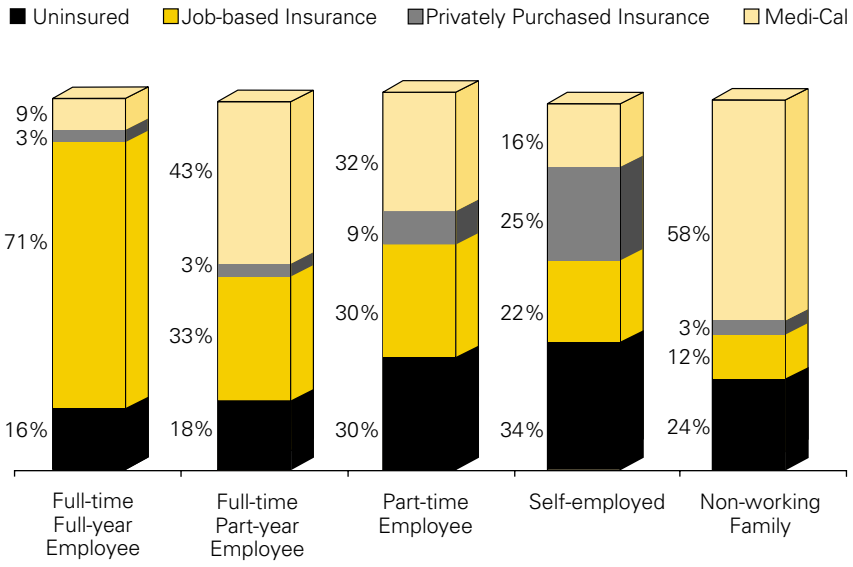
If the proportion of children in California's Medi-Cal and Healthy Families programs had not declined since 1994 and the proportions with job-based and privately purchased insurance had risen as they have, about 600,000 fewer children would have been uninsured in 1999. Thus, substantial further gains in children's coverage could be made by maintaining and expanding enrollments in these programs.

CHILDREN'S COVERAGE AND THEIR FAMILY'S WORK STATUS

Job-based coverage is highest (71%) for children in families with at least one parent who is a full-time, full-year employee (Exhibit 13) — the family work status that includes two-thirds of the state's children. But this job-based coverage declines dramatically when looking at other family employment status categories: 33% for children with at least one parent who is a full-time employee for at least part of the year; 30% for those with part-time employment; and 22% for those in families supported by self-employment (for whom privately purchased insurance covers one in four).

The expanding economy enabled more families to obtain more and better employment, increasing the proportion of California's children whose parents were full-time, full-year employees from 59% in 1994 to 65% in 1998 and finally to 68% in 1999. During this same period, the proportion of children in nonworking families fell from 18% in 1994 to 11% in 1998 and to just 9% in 1999. This

EXHIBIT 13. HEALTH INSURANCE COVERAGE OF CHILDREN BY FAMILY WORK STATUS, AGES 0-18, CALIFORNIA, 1999



Note: Includes persons reporting enrollment in Medi-Cal or the Healthy Families Program. Such estimates derived from surveys are generally lower than those derived from administrative data.

Source: March 2000 Current Population Survey

Nine in 10 uninsured children are in working families

improvement in the economy increased these families' incomes and their access to job-based insurance coverage for their children.

Medi-Cal and the Healthy Families Program form a safety net for many children in both nonworking and working families. Among those in families in which no adult worked during the year, 58% received Medi-Cal or Healthy Families coverage in 1999. This proportion is statistically the same as in 1998, when 54% of children in nonworking families had Medi-Cal or Healthy Families coverage, but it is far below the proportion in 1995 (76%), the year before welfare reform was enacted and three years before Healthy Families even began to accept enrollees.[19] One in four (24%) children in nonworking families was uninsured in 1999, an improvement over the previous year (33%), but a rate that is somewhat higher (although not significantly) than in 1994 before the enactment of welfare reform (19%).

Part of this improvement may be due to Los Angeles, San Francisco, Alameda and some other counties leaving many children on Medi-Cal longer than expected after their families left welfare. Children who initially had been enrolled through public assistance programs (that is, the former Aid to Families with Dependent Children or its CalWORKs replacement) were supposed to have their cases reviewed to determine whether they continued to be eligible for Medi-Cal after their post-welfare transition period ended. The delayed implementation of this policy benefited thousands of individuals who might have lost their Medi-Cal coverage had the "re-determination" been done immediately.

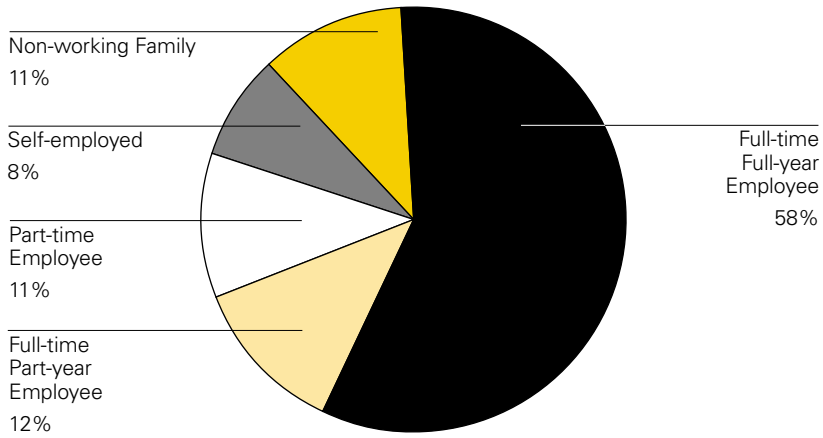
Children in working families also benefit from these programs, which covered 43% of those in full-time, part-year employee families in 1999 and 32% of those in families headed by a part-time employee.

As a result of their high rate of job-based coverage, children in full-time, full-year employee families have the lowest uninsured rate — 16% in 1999 — a rate that has changed little since 1994 (17%). Children in full-time, part-year employee families have a comparable uninsured rate (18%) due more to Medi-Cal coverage than to employment benefits. About one in three children whose parents are part-time employees (30%) or self-employed (34%) is uninsured.

Nine in 10 (89%) uninsured children are in working families (Exhibit 14) — a total of 1.6 million children. More than 1 million uninsured children are in families with at least one parent who is employed full-time for the full year — nearly six in 10 (58%) of all uninsured children in the state.

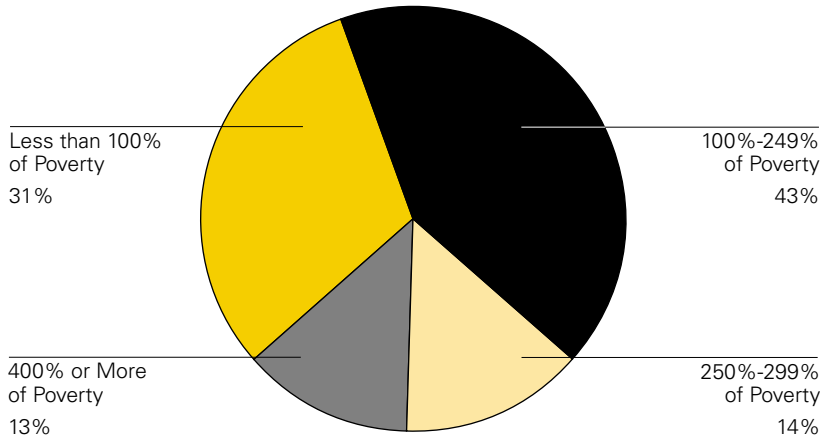
19 Medi-Cal/Medicaid and Healthy Families/CHIP estimates derived from surveys are generally lower than those derived from administrative data.

EXHIBIT 14. UNINSURED CHILDREN BY FAMILY WORK STATUS, AGES 0-18, CALIFORNIA, 1999



Source: March 2000 Current Population Survey

EXHIBIT 15. UNINSURED CHILDREN BY FAMILY INCOME RELATIVE TO POVERTY THRESHOLD, AGES 0-18, CALIFORNIA, 1999



Note: Numbers may not add up to 100% due to rounding.
Source: March 2000 Current Population Survey

HEALTH INSURANCE COVERAGE OF CHILDREN BY FAMILY INCOME

Three in 10 (31%) uninsured children live below poverty (below 100% of the federal poverty threshold) and another four in 10 (43%) have family incomes that are near the poverty level (100%-249% of poverty; Exhibit 15).[20] The low incomes of these uninsured children's families make the private purchase of health insurance unaffordable. These family incomes are also so low that required premium contributions for employer-provided family coverage are often unaffordable as well. Thus, any efforts to provide them with health insurance coverage will require substantial subsidies.

Fortunately, most of these children have options for receiving coverage through either Medi-Cal or the Healthy Families Program, as we will see. However, one in four (27%) uninsured children has a family income at least 250% of the poverty level, putting most of them out of range for public coverage programs. Unless income eligibility for public programs is raised to more generous levels, these children will have to depend on voluntary employer contributions for family coverage (reversing a long-established downward trend) or private charitable efforts.

20 In 1999, the poverty threshold was $8,667 for one person under age 65, $11,214 for a family of two under age 65, $13,290 for a family of three, and $17,029 for a family of four, etc.

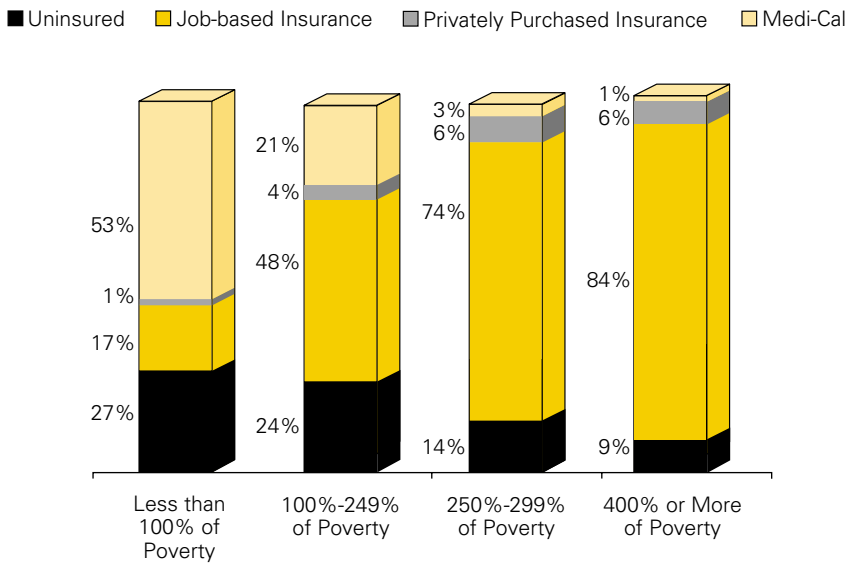
Seven in every 10 uninsured are in low- to moderate-income families

About one in four (27%) children living in families with incomes below the federal poverty level is uninsured (Exhibit 16) — the result of very low rates of job-based insurance (17%) that are only partially offset by high rates of coverage from Medi-Cal or the Healthy Families Program (53%). This group has lost ground since 1995, the year before welfare reform was enacted, when 62% were covered by Medi-Cal.

One in four (24%) near-poor children (those with family incomes 100%-249% of the poverty level) is also uninsured. Compared to those with family incomes below poverty, these children are more likely to receive employment-based health insurance (48%), but they are much less likely to receive Medi-Cal or Healthy Families coverage (21%).

Children in somewhat more affluent families (those with incomes between 250% and 399% of poverty) are far more likely to have job-based coverage (74%), resulting in a lower uninsured rate (14%). Children above that level are least likely to be uninsured (9%) because of their higher rates of job-based coverage (84%).

EXHIBIT 16. HEALTH INSURANCE COVERAGE OF CHILDREN BY FAMILY INCOME RELATIVE TO POVERTY THRESHOLD, AGES 0-18, CALIFORNIA, 1999



Note: Includes persons reporting enrollment in Medi-Cal or the Healthy Families Program. Such estimates derived from surveys are generally lower than those derived from administrative data.

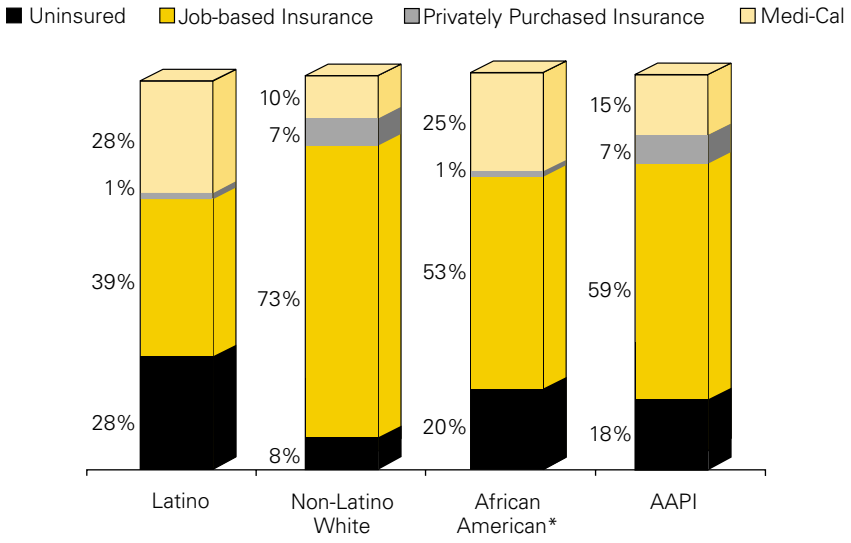
Source: March 2000 Current Population Survey

HEALTH INSURANCE COVERAGE OF CHILDREN BY RACE AND ETHNICITY

Latino children have the highest uninsured rates (28%) and lowest rates of job-based coverage (39%) of all major ethnic groups (Exhibit 17). African-American and Asian-American/Pacific Islander children also have uninsured rates that are more than twice the rate for whites. For all these groups, having health insurance obtained through parents' employment is the primary determinant of whether the child is uninsured, but Medi-Cal and the Healthy Families Program partially offset low rates of job-based insurance.

Overall, the uninsurance rate for children in California was 1 percentage point less in 1999 than in 1994 (not a statistically significant change), but that improvement reflected the substantial gains experienced by white children, who account for 40% of the state's children. Their uninsured rate fell from 14% to 8% during this period (Exhibit 18), as their coverage through parent's employment rose with the economic recovery and expansion (from 66% to 73%), despite an apparent (but not statistically significant) decline in Medi-Cal coverage (from 13% to 10%).

EXHIBIT 17. HEALTH INSURANCE COVERAGE OF CHILDREN BY ETHNIC GROUP, AGES 0-18, CALIFORNIA, 1999



* Estimates for African-American children are two-year averages of March 1999 and 2000 Current Population Surveys, which are more stable than one-year estimates. Sample sizes for American Indian/Alaska Native children are too small to provide a statistically acceptable estimate.

Note: Includes persons reporting enrollment in Medi-Cal or the Healthy Families Program. Such estimates derived from surveys are generally lower than those derived from administrative data.

Source: March 2000 Current Population Survey

Racial and ethnic disparities remain, despite improvements for some groups

Latino children ended the 1990s with the same uninsured rate as in 1994 (28%) — despite a seeming (but not statistically significant) increase in job-based insurance coverage.

Even among children in families headed by at least one employee who works full time year round, Latino children are less likely to receive job-based insurance and more likely to be uninsured than white children. In 1999, only 51% of Latino children in full-time, full-year employee families were covered by job-based insurance (compared to 85% of white children) and 28% of Latinos were uninsured (compared to 6% of whites).

Uninsured rates worsened for Asian-American and Pacific Islander children (14% in 1994 and 18% in 1999) and for African-American children (13% in 1994 and 20% in 1999). Gains in overall coverage were made among non-Latino white children, whose uninsured rate dropped from 14% in 1994 to 8% in 1999.

EXHIBIT 18. HEALTH INSURANCE COVERAGE OF CHILDREN BY ETHNIC GROUP, AGES 0-18, CALIFORNIA, 1994 AND 1999

	NON-LATINO WHITE		LATINO		ASIAN AMERICAN/ PACIFIC ISLANDER		AFRICAN AMERICAN*	
	1994	1999	1994	1999	1994	1999	1994	1999
UNINSURED	14%	8%	28%	28%	14%	18%	13%	20%
JOB-BASED INSURANCE	66%	73%	36%	39%	51%	59%	43%	53%
PRIVATELY PURCHASED	6%	7%	1%	1%	3%	7%	1%	1%
MEDI-CAL/ HEALTHY FAMILIES**	13%	10%	35%	28%	27%	15%	38%	25%
OTHER PUBLIC	2%	2%	<1%	3%	4%	2%	4%	1%
TOTAL	100%	100%	100%	100%	100%	100%	100%	100%
POPULATION IN 2000	4,021,000		4,011,000		1,203,000		580,000	

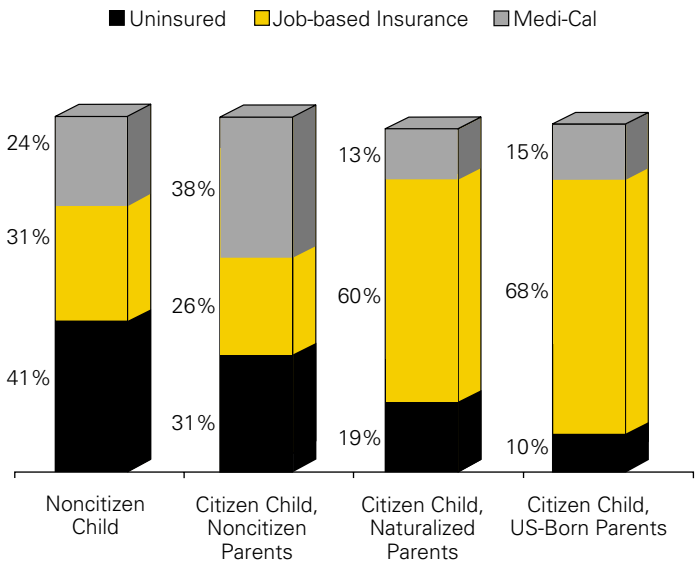
* Estimates for African-American children are two-year averages of March 1995-1996 and March 1999-2000 Current Population Surveys, which are more stable than one-year estimates. Sample sizes for American Indian/Alaska Native children are too small to provide a statistically acceptable estimate.

** Includes persons reporting enrollment in Medi-Cal (1994 and 1999) or the Healthy Families Program (1999) in California. Such estimates derived from surveys are generally lower than those derived from administrative data.

Note: Numbers may not add to 100% due to rounding. Population estimate is based on March 2000 Current Population Survey, which may differ from population estimates derived from other sources.

Source: March 1995 and 2000 Current Population Surveys

EXHIBIT 19. HEALTH INSURANCE COVERAGE OF CHILDREN BY FAMILY IMMIGRANT AND CITIZENSHIP STATUS, AGES 0-18, CALIFORNIA, 1999



Note: Includes persons reporting enrollment in Medi-Cal or the Healthy Families Program. Such estimates derived from surveys are generally lower than those derived from administrative data.

Source: March 2000 Current Population Survey

WELFARE REFORM AND IMMIGRANT FAMILIES

Health insurance coverage of children varies greatly by their parents' and their own immigrant and citizenship status. Four in 10 (41%) noncitizen children and three in 10 (31%) U.S.-citizen children with noncitizen parents were uninsured in 1999 — three to four times the uninsured rate for citizen children with U.S.-born parents (10%; Exhibit 19). Thus, being a noncitizen increases a child's risk of being uninsured, but even citizen children in "mixed status" families (that is, with one or more parents who are noncitizens) bear several times the risk of being uninsured compared to those with U.S.-born parents. Citizen children with naturalized parents fare better (19% uninsured), but their uninsured rate is nearly twice that of citizen children with U.S.-born parents.

Most of the disparities in uninsured rates are driven by differences in children's access to employment-based health insurance. Job-based insurance coverage ranges from 26% and 31% for U.S.-citizen children with noncitizen parents and noncitizen children, respectively, (rates that are not significantly different from each other) to 60% for citizen children with naturalized parents and 68% for those with U.S.-born parents (Exhibit 19).

Four in 10 noncitizen children and three in 10 U.S.-citizen children with noncitizen parents were uninsured in 1999 — three to four times the rate for those with U.S.-born parents

EXHIBIT 20. MEDI-CAL/HEALTHY FAMILIES COVERAGE OF CHILDREN BY FAMILY IMMIGRANT AND CITIZENSHIP STATUS, AGES 0-18, CALIFORNIA, 1994, 1998 AND 1999**

	1994	1998	1999	CHANGE 1994-1999	CHANGE 1998-1999	POPULATION IN 2000
NONCITIZEN CHILD	40%	18%	24%	–16*	+6*	789,000
CITIZEN CHILD, NONCITIZEN PARENTS	42%	35%	38%	–4	+3	1,584,000
CITIZEN CHILD, NATURALIZED PARENTS	10%	15%	13%	+3	–2	2,374,000
CITIZEN CHILD, US-BORN PARENTS	19%	16%	15%	–4*	–1	5,041,000

* Estimates for African-American children are two-year averages of March 1995-1996 and March 1999-2000 Current Population Surveys, which are more stable than one-year estimates. Sample sizes for American Indian/Alaska Native children are too small to provide a statistically acceptable estimate.

** Includes persons reporting enrollment in Medi-Cal (1994-1999) or the Healthy Families Program (1998 and 1999) in California. Such estimates derived from surveys are generally lower than those derived from administrative data.

Note: Population estimate is based on March 2000 Current Population Survey, which may differ from population estimates derived from other sources.

Source: March 1995, 1999 and 2000 Current Population Survey

This disparity by immigrant and citizenship status is very important in California, where 24% of all children are noncitizens or in mixed-status families, and another 24% are in families with naturalized parents. Immigration and citizenship issues affect Latino and Asian American/Pacific Islander children more than other groups. Among Latino children, about half (49%) are noncitizens or are citizens but have at least one noncitizen parent, and another one-fourth (28%) have naturalized parents. Among Asian American/Pacific Islanders, 21% are noncitizens or have at least one noncitizen parent, and two-thirds (68%) have naturalized parents. But this does not adequately explain Latino children's very high uninsured rate because even among children with U.S.-born parents, Latino children are much less likely than whites to receive job-based insurance (56% vs. 75%) and more likely to be uninsured (16% vs. 7%).

Policy makers have expanded Medi-Cal and enacted the Healthy Families Program to increase coverage for low- and moderate-income children who do not have access to employment-based health insurance. But welfare reform created a countervailing force that decreased public coverage of many children in immigrant families. Welfare reform imposed more stringent eligibility policies that discouraged many noncitizens from applying for Medi-Cal, resulting in a 16 percentage-point drop in Medi-Cal coverage between 1994 and 1999, although their coverage rose significantly between 1998 and 1999 (Exhibit 20). Medi-Cal coverage also declined (albeit not significantly) among U.S.-citizen children with noncitizen parents, from 42% in 1994 to 38% in 1999, and among citizen children with U.S.-born parents, from 19% in 1994 to 15% in 1999 (a statistically significant decline).

During this same period, Medi-Cal coverage for citizen children with naturalized parents rose from 10% in 1994 (when 68% had employment-based coverage) to 15% in 1998 and declined to 13% in 1999 (when 60% had

EXHIBIT 21. HEALTH INSURANCE COVERAGE OF CHILDREN BY FAMILY COMPOSITION, AGES 0-18, CALIFORNIA, 1994 AND 1999

	MARRIED-COUPLE FAMILY			SINGLE-PARENT FAMILY		
	1994	1999	CHANGE 1994-1999	1994	1999	CHANGE 1994-1999
UNINSURED	18%	16%	–2*	22%	25%	+3
JOB-BASED INSURANCE	59%	64%	+5*	32%	36%	+4*
PRIVATELY PURCHASED	4%	5%	+1*	2%	2%	–
MEDI-CAL/HEALTHY FAMILIES**	17%	13%	–4*	43%	35%	–8*
OTHER PUBLIC	2%	2%	–	1%	2%	+1
TOTAL	100%	100%		100%	100%	
POPULATION IN 2000	7,218,000			2,569,000		

* Estimates for African-American children are two-year averages of March 1995-1996 and March 1999-2000 Current Population Surveys, which are more stable than one-year estimates. Sample sizes for American Indian/Alaska Native children are too small to provide a statistically acceptable estimate.

** Includes persons reporting enrollment in Medi-Cal (1994 and 1999) or the Healthy Families Program (1999) in California. Such estimates derived from surveys are generally lower than those derived from administrative data.

Note: Numbers may not add to 100% due to rounding. Population estimate is based on March 2000 Current Population Survey, which may differ from population estimates derived from other sources.

Source: March 1995 and 2000 Current Population Survey

employment-based insurance), resulting in an increase in their uninsured rate from 13% in 1994 to 19% in 1999. Based on changes in the reported status of parents, it is likely that some of this increase in Medi-Cal coverage was due to noncitizen parents becoming U.S. citizens.

WELFARE REFORM AND FAMILY COMPOSITION

People who had the fewest alternative options for obtaining health insurance suffered the most from the adverse effects of welfare reform. Children living in families headed by a married couple have two chances of obtaining health insurance through a parent's employment, while children in single-parent headed families have only one chance.[21] Although Medi-Cal coverage of children in married-couple families fell 4 percentage points between 1994 and 1999, the economic recovery and boom pushed up their employment-based health insurance from 59% to 64%, with a net reduction in their uninsured rate of 2 percentage points (Exhibit 21).

21 This general pattern may be qualified in some instances. Children in married-couple families have two chances of obtaining job-based insurance if both parents are working, but only one chance if just one parent is employed. Children in single-parent headed families have two chances of obtaining job-based insurance if a step-parent outside the household is able to provide it.

Children living with two parents experienced an increase in employment-based insurance between 1994 and 1999 and a decrease in their uninsured rate

Children in single-parent families did not fare so well. Their Medi-Cal coverage plummeted 8 percentage points between 1994 and 1999. Although economic growth increased their job-based coverage by 4 percentage points, the proportion who are uninsured increased (but not significantly) 3 percentage points.

As a result of welfare reform and these changes in Medi-Cal and employment-based health insurance, there is a growing disparity between children in single-parent and married-couple families. One in four (25%) children who live with one parent is uninsured, compared to 16% of those who live with two parents (data not shown).

Latino children are somewhat less likely than non-Latino whites to live with two parents (71% vs. 77%), which might partly explain their higher uninsured rate. However, even among those in two-parent families, Latino children are less likely than white children to receive employment-based health insurance (46% vs. 78%) and more likely to be uninsured (27% vs. 6%).

Children in single-parent families also gained employment-based insurance but their Medi-Cal coverage fell so fast that their uninsured rate increased

EXHIBIT 22. UNINSURED AND JOB-BASED INSURANCE RATES OF CHILDREN BY COUNTY OF RESIDENCE, AGES 0-18, CALIFORNIA, 1997-1999 (3-YEAR AVERAGE)

	UNINSURED[1]		JOB-BASED INSURANCE[1]		UNEMPLOYMENT	POPULATION AGES 0-18
COUNTY/COUNTY GROUP[5]	**RATE**	**RANGE[2]**	**RATE**	**RANGE[2]**	**RATE[3]**	**1998[4]**
NORTHERN CALIFORNIA[6, 7]	12%		56%		—	—
BUTTE	22%	13%-32%	36%	25%-46%	7.9%	51,755
SACRAMENTO	13%	9%-17%	57%	51%-64%	4.9%	345,922
YUBA, SUTTER	26%	19%-34%	43%	33%-52%	13.9%	46,042
GREATER BAY AREA[6, 7]	12%		71%		—	—
ALAMEDA	9%	4%-13%	75%	69%-82%	4.0%	388,592
CONTRA COSTA	9%	4%-13%	83%	77%-89%	3.6%	247,619
MONTEREY	18%	8%-27%	41%	29%-53%	10.3%	120,604
NAPA, SOLANO	*		67%	59%-76%	5.2%	147,970
SAN FRANCISCO	27%	18%-37%	50%	39%-61%	3.6%	157,126
SAN MATEO	14%	6%-21%	78%	68%-87%	2.4%	183,152
SANTA CLARA	13%	9%-17%	71%	66%-76%	3.1%	461,762
CENTRAL VALLEY[7]	15%		50%		—	—
FRESNO, MADERA	11%	6%-16%	52%	44%-59%	13.5%	303,909
MERCED	15%	8%-21%	50%	41%-59%	14.6%	73,553
SAN JOAQUIN	13%	7%-19%	47%	38%-56%	10.0%	174,985
STANISLAUS	*		54%	43%-64%	11.9%	140,037
TULARE	25%	17%-32%	33%	25%-42%	15.8%	126,178
SOUTHERN CALIFORNIA[7, 8]	19%		59%		—	—
KERN	21%	14%-27%	54%	46%-63%	11.9%	214,181
ORANGE	19%	16%-23%	63%	58%-67%	2.9%	801,376
RIVERSIDE, SAN BERNARDINO	20%	17%-23%	56%	52%-60%	6.0%	1,012,826
SAN DIEGO	19%	15%-22%	57%	52%-61%	3.6%	804,872
SAN LUIS OBISPO	19%	10%-29%	53%	40%-66%	4.0%	55,894
SANTA BARBARA	33%	21%-44%	48%	36%-60%	4.4%	108,804
VENTURA	*		79%	71%-86%	5.6%	216,224
LOS ANGELES	27%	25%-29%	46%	44%-48%	6.4%	2,919,064
ALL OTHER COUNTIES[7]	*		52%		—	—

Source: March 1998, 1999 and 2000 Current Population Surveys

1 These estimates of health insurance coverage are three-year averages, which are more stable than one-year estimates.

2 Reported rates are estimates. The true rate is likely to fall in this range (95% confidence interval).

3 The unemployment rates are three-year averages computed from data published by the California Employment Development Department, Labor Market Information Division, Information Services Group. These rates are not seasonally adjusted.

4 The population numbers are California State Department of Finance estimates for each county for January 1, 1998.

5 Counties not shown fall into two categories: (1) the county was not sampled in the March Current Population Survey (CPS) — for example Santa Cruz county; (2) estimates for both the uninsured and job-based insurance rates were not statistically stable. Additionally, county groups displayed in the exhibit reflect CPS sampling of the area — for example Riverside, San Bernardino.

6 The Northern California rate includes El Dorado, Placer and Yolo counties and the Greater Bay Area rate includes Marin and Sonoma. These counties are not shown individually because of unstable rates.

7 Regional rates are one-year estimates for 1999, data source March CPS 2000.

8 The Southern California rate excludes Los Angeles county.

* Does not meet minimum standards for precision.

CHILDREN'S HEALTH INSURANCE COVERAGE DIFFERS FROM COUNTY TO COUNTY

Health insurance coverage of children varies markedly from county to county. Exhibit 22 provides three-year averages of county-level estimates for children ages 0-18.[22] Despite averaging three years of data, the range for each county-specific health insurance estimate for children is more reliable than the point estimate. More precise county-level health insurance coverage estimates will be available from the California Health Interview Survey (CHIS).

The relationship between job-based coverage and unemployment for children is similar to that of the nonelderly overall. The Bay Area, except San Francisco, has low unemployment and high job-based coverage, while the Central Valley has higher unemployment and lower job-based health insurance. San Francisco, Los Angeles, and other Southern California counties reflect a different pattern: low unemployment yet low coverage rates for their workers. Employment-based coverage for children spans a wide range across counties — from 33% in Tulare County to a high of 83% in Contra Costa County (again, with a wide margin of error for most counties).

Children's uninsured rates vary from Santa Barbara, Los Angeles and San Francisco at the high end to Alameda and Contra Costa at the low end. (We emphasize that these estimates for children may be unreliable due to small sample sizes.)

UNINSURED CHILDREN: A POSITIVE TURN IN A LONGER DISMAL TREND

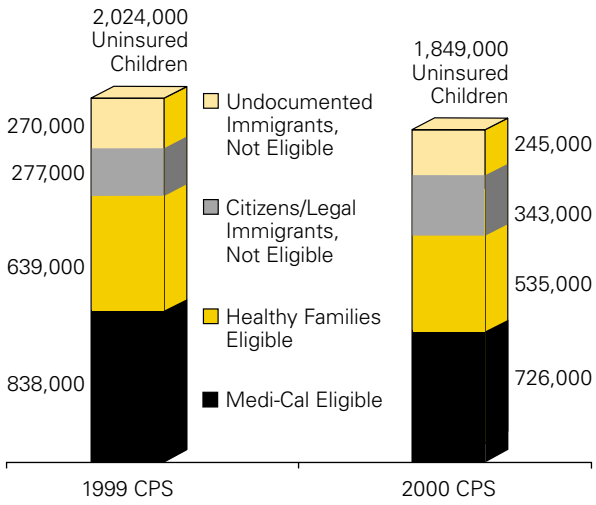
To sum up, the number and proportion of children in California who are uninsured declined in the past year, as has been the case nationally. This positive change is a result of expanding employment-based health insurance due to the booming economy, together with a slower decline in public coverage. Stabilized public coverage appears to be due to extensive efforts to enroll children in Medi-Cal and Healthy Families and perhaps to diminished concern about the "public charge" issue. This is a very welcome change from the trend between 1995 and 1998, when Medi-Cal coverage significantly declined while job-based insurance, privately purchased insurance, and other sources showed little change — despite the strong economic recovery.

This good news should be weighed together with the recognition that California's children are at higher risk of being uninsured than children in the nation as a whole due to their families' poorer access to employment-based health insurance. Furthermore, children of color — African Americans, Asian American/Pacific Islanders, and especially Latinos — have uninsured rates that are much higher than the most advantaged group, non-Latino whites. Their higher rates are due both to lower rates of job-based insurance — a consequence of the labor market in the U.S. voluntary coverage system — and dramatic declines in coverage through Medi-Cal, a consequence of public policy.

22 As with the nonelderly estimates in Exhibit 9, we present three-year estimates of children's health insurance coverage to obtain more precise estimates for counties.

Health insurance coverage of children varies widely from county to county

EXHIBIT 23. UNINSURED CHILDREN BY ELIGIBILITY FOR MEDI-CAL AND HEALTHY FAMILIES, AGES 0-18, CALIFORNIA



Source: Estimates of eligibility calculated by the UCLA Center for Health Policy Research based on data from the March 1999 and 2000 Current Population Survey

OPPORTUNITIES TO COVER UNINSURED CHILDREN: THE HEALTHY FAMILIES AND MEDI-CAL PROGRAMS[23]

California has enormous opportunities to expand health insurance coverage for its uninsured children through its public programs. More than two-thirds of the state's 1.85 million uninsured children are eligible for either Medi-Cal or the Healthy Families Program. As the number of uninsured children has declined, the numbers who are eligible for these programs has fallen from 1.5 million based on 1999 CPS data to 1.3 million based on 2000 CPS data — a change that is not statistically significant.

Based on the most recent data available, 29% of uninsured children are eligible for Healthy Families — a total of 535,000 children (range: 455,000 to 614,000; Exhibit 23).[24] This is an apparent (but not statistically significant) decrease from the estimate of 639,000 (range: 543,000 to 736,000) based on the previous year's data. Not enrolling a

23 Hongjian Yu, Ph.D., performed the complex modeling of Medi-Cal and Healthy Families eligibility, with extensive collaboration by Jennifer Kincheloe, M.P.H.

24 Reported numbers are estimates based on small sample sizes, which reduce the estimate's precision and reliability. The range (called, a "95% confidence interval") provides a more reliable estimate of the numbers of persons in the population who fit that category. It means that the "true" estimate has a 95% probability of falling within the range.

More than two-thirds of California's 1.85 million uninsured children are eligible for either Medi-Cal or the Healthy Families Program

sufficient number of children in Healthy Families cost California $590 million in federal matching funds that had been available to the state but remained unspent by the deadline of September 30, 2000.[25]

Another 39% of uninsured children are eligible for Medi-Cal — a total of 726,000 children (range: 633,000 to 817,000). This also is an apparent (but not statistically significant) change from the previous year's estimate of 838,000 (range: 728,000 to 949,000).

Approximately three-fourths of all uninsured children who are eligible for Medi-Cal are in working families, and about half of these children are in families headed by at least one full-time, full-year employee. An even larger proportion of children who are eligible for the Healthy Families Program have working parents; three-fourths have at least one parent who works full-time, full-year for an employer without getting employment-based health benefits.

Although none of the differences between 1999 and 2000 are statistically significant, there does appear to be a small shift. The lower numbers in the most recent data may be due to a combination of three factors. First, continuing improvements in the economy enhanced children's coverage through their parents' employment, reducing the number who are uninsured. The number of children with job-based insurance rose about 300,000 between 1998 and 1999, while the number who are uninsured fell by 176,000.

Second, these economic improvements have also led to growing family incomes, even for some uninsured children. The proportion of all children with family incomes below poverty fell from 24% to 21% between 1998 and 1999 while those with incomes of 400% of poverty or more increased from 24% to 27%; the proportion with family incomes between 100% and 250% of poverty remained flat at about one in three. These higher family incomes reduced the proportion of uninsured children with Medi-Cal income eligibility. As earnings rose, however, the proportion and the number of uninsured children whose family incomes exceeded the Healthy Families limit also grew, from 14% of all uninsured children — a total of 277,000 (range: 214,000 to 341,000) based on 1999 CPS data — to 19% of all uninsured children — 343,000 (range: 279,000 to 407,000) based on 2000 CPS data (a statistically significant increase).

Third, expanded outreach and enrollment efforts have paid off with growing enrollments in the Healthy Families Program. The number of enrollees in Healthy Families rose from 53,000 in December 1998 to 206,000 in December 1999 to 355,000 in December 2000.[26] Approximately 2.7 million children (under age 21) were enrolled in Medi-Cal in January 2000, only slightly changed from the 2.8 million one year earlier.[27] (The Medi-Cal enrollees data include all children of those ages, not just the ones who were enrolled through the children's percent-of-poverty program.) All three of these explanations are welcome news, bringing benefits for California's children.

25 Pear R, "40 States Forfeit Health Care Funds for Poor Children," *New York Times*, September 23, 2000.

26 The numbers of Healthy Families enrollees were provided by Sandra Shewry, Executive Director, California Managed Risk Medical Insurance Board, personal communication, Dec. 20, 2000.

27 Based on administrative data from the Monthly Medi-Cal Eligibility File (MMEF), table with data for January 1996 to June 2000 (http://www.dhs.ca.gov/mcss/RequestedData/Ages/age.htm). The number of enrollees based on Medicaid administrative data are generally higher than estimates derived from the Current Population Survey or other surveys.

Declining uninsurance of children in the last year appears due to growing employment opportunities for their parents, rising family incomes, and improved outreach and enrollment in Medi-Cal and Healthy Families

We estimate that, based on 2000 CPS data, another 245,000 (range: 191,000 to 300,000) uninsured children were undocumented immigrants (about 13% of the total) and therefore not eligible for either program, except for emergency medical services and prenatal care under Medi-Cal if they have very low income. (This estimate is not statistically different from the estimate of 270,000, which falls within the range of 214,000 to 341,000, based on 1999 CPS data. Undocumented status is not available in the CPS; we imputed it using a method described in the Appendix.)

California has worked to improve its outreach to families of uninsured eligible children and to enroll them in one of these programs. These efforts were initially hampered by many flaws:

- an incredibly lengthy and unnecessarily complicated application (a 28-page application booklet since reduced to 10 pages),
- an unnecessarily complex application process (e.g., burdensome and unnecessary documentation requirements),
- uncertainty among noncitizens about whether enrolling their children would jeopardize their status in this country (partially resolved by new federal policy statements about "public charge" classification, issued in May 1999),
- recertification procedures in Medi-Cal that dropped out large numbers of eligible children (with quarterly recertification now being replaced for children by 12-month continuous eligibility — although the success of this policy change will be determined by its implementation),
- a lingering stigma related to Medi-Cal's welfare system procedures (only partially addressed by the use of mail-in applications since welfare office interviews still may be required), and
- a weak outreach campaign that relied too much on traditional media and too little on experienced community-based organizations (whose roles are gradually being increased).

In Part 5 of this report, we offer a number of recommendations that could dramatically improve outreach and enrollment of children.

The number of uninsured children who are citizens or legal immigrants and whose family incomes exceed the Healthy Families limit grew to 343,000 — 19% of all uninsured children — in the most recent year

3. HEALTH INSURANCE COVERAGE OF ADULTS

3

Nonelderly adults are at even greater risk than children of being uninsured. Although adults ages 19-64 are more likely than children to have employment-based health insurance coverage, they are less likely to be eligible for the public programs that protect children and the elderly. California's 5 million uninsured adults account for nearly three-fourths of the state's uninsured population.

DIFFERENCES BY AGE GROUP

Young adults, ages 19-24, have the highest risk of being uninsured. In 1999, only 48% of persons ages 19-24 had employment-based insurance, more than half of whom received that coverage as dependents (Exhibit 24). Another 3% were covered by privately purchased insurance, and 9% were covered by Medi-Cal, leaving 38% uninsured. In contrast, 69% of persons ages 40-54 had employment-based coverage (including 51% who received it in their own name and 18% of whom received it as dependents), another 6% had privately purchased insurance, and 6% had Medi-Cal coverage, leaving only 18% uninsured — about the same rate as children.

These differences reflect the disparities that inevitably result from a health insurance system that relies on voluntary provision of health benefits by employers as the primary source of coverage. Young adults have high rates of enrollment in school and are just entering the labor market; those who are working often find themselves in entry-level jobs without the combination of education and experience that might give them more clout in negotiating wages and benefits. Also, working young adults (ages 19-24) take up employment-based coverage (82%) at lower rates than older workers (87% for 25-44 year olds and 89% for 45-64 year olds). Their higher dependent coverage reflects the substantial proportion that receives health insurance coverage through their parent's policy. Individuals ages 40-54, on the other hand, are at their peak in the labor market, with the combination of education and work experience that generates high rates of coverage. A significant portion of those who are not covered in their own name are able to be covered by a spouse.

EXHIBIT 24. HEALTH INSURANCE COVERAGE OF NONELDERLY ADULTS BY AGE GROUP, AGES 19-64, CALIFORNIA, 1999

	19-24 YRS	25-29 YRS	30-39 YRS	40-54 YRS	55-64 YRS
UNINSURED	38%	32%	24%	18%	19%
JOB-BASED INSURANCE	48%	56%	64%	69%	65%
PRIMARY ENROLLEE	20%	45%	46%	51%	50%
DEPENDENT COVERAGE	28%	11%	18%	18%	15%
PRIVATELY PURCHASED	3%	4%	4%	6%	6%
MEDI-CAL	9%	6%	6%	6%	6%
OTHER PUBLIC	2%	1%	1%	1%	4%
TOTAL	100% (POPULATION: 2,997,000)	100% (POPULATION: 2,473,000)	100% (POPULATION: 5,379,000)	100% (POPULATION: 6,933,000)	100% (POPULATION: 2,656,000)

Note: Numbers may not add to 100% due to rounding. Population estimate is based on March 2000 Current Population Survey, which may differ from population estimates derived from other sources.

Source: March 2000 Current Population Survey

Young adults have highest rate of uninsurance

HEALTH INSURANCE COVERAGE BY FAMILY INCOME

Half of nonelderly adults with family incomes below poverty are completely uninsured — a result of their very low access to job-based insurance and despite one in four being covered by Medi-Cal (Exhibit 25). The risk of being uninsured is much lower at higher incomes, declining to 39% among the near poor (between 100% and 249% of poverty) and falling to one in 10 among the most affluent group. The risk of uninsurance falls as the probability of receiving employment-based health insurance rises.

EXHIBIT 25. HEALTH INSURANCE COVERAGE OF NONELDERLY ADULTS BY FAMILY INCOME RELATIVE TO POVERTY, AGES 19-64, CALIFORNIA, 1999

	BELOW POVERTY	100% TO 249% OF POVERTY	250% TO 399% OF POVERTY	400% OF POVERTY OR HIGHER
UNINSURED	51%	39%	21%	10%
JOB-BASED INSURANCE	18%	43%	70%	83%
PRIVATELY PURCHASED	3%	5%	6%	5%
MEDI-CAL	26%	11%	2%	1%
OTHER PUBLIC	2%	2%	2%	1%
TOTAL	100% (POPULATION: 2,396,000)	100% (POPULATION: 5,111,000)	100% (POPULATION: 4,126,000)	100% (POPULATION: 8,805,000)

Note: Numbers may not add to 100% due to rounding. Population estimate is based on March 2000 Current Population Survey, which may differ from population estimates derived from other sources.

Source: March 2000 Current Population Survey

More than 1.2 million very-low income adults are uninsured

The high rate of uninsurance among poor adults results in this income group accounting for one in four uninsured adults (25%, data not shown), twice their share of the nonelderly adult population. This group of very low-income adults — a total of 1,231,000 persons — will need essentially full subsidies to make health insurance coverage affordable. The near poor account for four in 10 (40%) uninsured adults — a total of 1,974,000 persons; this group will need significant subsidies as part of any public or private efforts to extend health insurance coverage to them.

The low rate of uninsurance among adults with incomes at least four times the poverty level generates a disproportionately small share of uninsured adults. This income group accounts for 18% of uninsured adults, while it represents 43% of California's nonelderly adult population. This income group is clearly able to pay a considerable share of health insurance premiums, but other factors may make health insurance difficult to get or difficult to afford. For example, pre-existing conditions may result in refusals by health plans to provide coverage in the individual market, or to provide it but charge high premiums and exclude particular conditions from coverage.

ETHNIC AND RACIAL DISPARITIES IN COVERAGE

Latino nonelderly adults are much less likely to have employment-based health insurance than whites (Exhibit 26). Despite a somewhat higher rate of Medi-Cal coverage, their low job-based coverage results in four in every 10 Latino nonelderly adults being uninsured — a rate that is nearly three times that of whites. Latinos' uninsured rate is nearly twice that of African Americans and Asian Americans/Pacific Islanders, who are protected by higher rates of employment-based health benefits.

Latinos are less likely than whites to receive health insurance coverage in their own name regardless of how much they work, the size firm in which they work, or their

EXHIBIT 26. HEALTH INSURANCE COVERAGE OF NONELDERLY ADULTS BY ETHNIC GROUP, AGES 19-64, CALIFORNIA, 1999

	NON-LATINO WHITE	LATINO	ASIAN AMERICAN/ PACIFIC ISLANDER	AFRICAN AMERICAN
UNINSURED	15%	41%	25%	21%
JOB-BASED INSURANCE	72%	45%	65%	61%
PRIVATELY PURCHASED	7%	2%	5%	3%
MEDI-CAL	4%	10%	4%	13%
OTHER PUBLIC	1%	1%	2%	2%
TOTAL	100% (POPULATION: 10,680,000)	100% (POPULATION: 5,730,000)	100% (POPULATION: 2,589,000)	100% (POPULATION: 1,209,000)

Note: Numbers may not add to 100% due to rounding. Population estimate is based on March 2000 Current Population Survey, which may differ from population estimates derived from other sources.

Source: March 2000 Current Population Survey

Among full-time workers, Latinos have low job-based coverage

education level. Only 57% of Latinos who work full-time, full-year receive health benefits in their own name, compared to 82% of whites (data not shown). Only 26% of Latinos in firms with fewer than 10 workers receive their own job-based insurance compared to 53% of whites, while 44% of Latinos in firms with 10-24 workers receive their own health benefits compared with 71% of whites. The same differences are seen in the largest firms (those with 1,000 or more workers), in which 67% of Latinos receive job-based insurance compared to 86% of whites. This risk is compounded by the fact that Latinos are also slightly less likely to work full-time, full-year and are slightly more likely to work in small firms.

Latinos are far more likely to have less than a high school education and much less likely to have attended college, a great handicap when health benefits are distributed based on labor market competition. But Latinos are also less likely to receive these benefits at every level of education. Nearly half (47%) of Latino nonelderly adults have less than a high school education (compared to 5% of whites), and only 20% have job-based insurance in their own names (compared to 30% of whites). A similar Latino-white disparity in employment-based health benefits prevails among those with a college education.

DISPARITIES BY CITIZENSHIP AND IMMIGRATION STATUS

U.S.-born adults are far less likely to be uninsured than are naturalized citizens and noncitizens because U.S.-born citizens are the most likely to receive employment-based health insurance (Exhibit 27). Among U.S.-born citizens, 70% had job-based insurance in 1999, compared to 63% of naturalized citizens, 46% of noncitizens who are legal residents, and just 31% of undocumented immigrants.

These disparities are due to several factors. Noncitizens, whether legal residents or undocumented, are somewhat younger and have lower levels of educational attainment. But their lack of citizenship also makes them vulnerable in the labor market and therefore less likely to be able to secure health benefits or wages that are comparable

EXHIBIT 27. HEALTH INSURANCE COVERAGE OF NONELDERLY ADULTS BY IMMIGRANT AND CITIZENSHIP STATUS, AGES 19-64, CALIFORNIA, 1999

	US-BORN CITIZEN	NATURALIZED CITIZEN	NONCITIZEN, LEGAL RESIDENT	NONCITIZEN, UNDOCUMENTED*
UNINSURED	17%	23%	36%	65%
JOB-BASED INSURANCE	70%	63%	46%	31%
PRIVATELY PURCHASED	5%	7%	2%	2%
MEDI-CAL	6%	6%	14%	<1%
OTHER PUBLIC	2%	2%	<1%	2%
TOTAL	100% (POPULATION: 13,480,000)	100% (POPULATION: 2,488,000)	100% (POPULATION: 2,685,000)	100% (POPULATION: 1,789,000)

* Estimates of undocumented immigrant status are modeled; see Appendix for explanation.

Note: Numbers may not add to 100% due to rounding. Population estimate is based on March 2000 Current Population Survey, which may differ from population estimates derived from other sources.

Source: March 2000 Current Population Survey

Noncitizens have extremely low rates of job-based insurance, but even legal residents and naturalized citizens have lower rates than U.S.-born citizens

to those of citizens. Noncitizens who are undocumented are particularly vulnerable to working in jobs that don't offer coverage (see Part 5). The high rates of noncitizenship account for some of the disparities in coverage between Latinos and whites, but within every citizenship group Latinos are less likely to receive job-based health benefits and more likely to be uninsured.

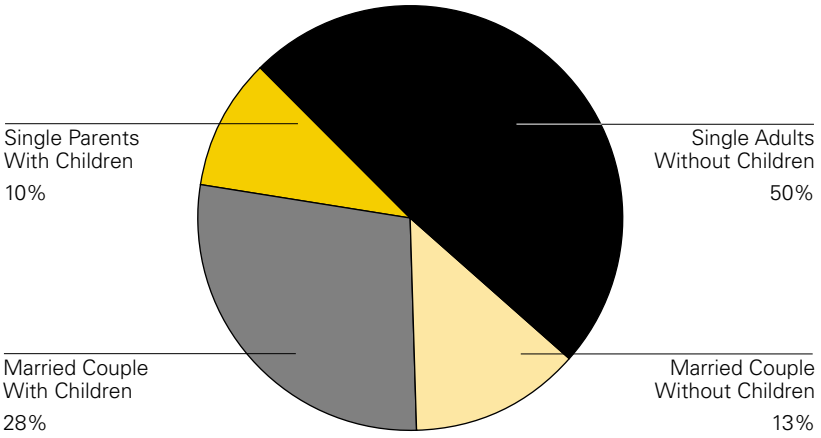
Despite their lower rate of uninsurance, citizens account for nearly six out of every 10 uninsured nonelderly adults (57%). Nevertheless, the fact that nearly two-thirds of undocumented immigrants and more than one-third of noncitizen legal residents are uninsured is a public health and social justice problem of great magnitude. The state's 4.5 million noncitizen adults represent 22% of all nonelderly adult Californians and an important part of the state's labor force.

HEALTH INSURANCE COVERAGE OF ADULTS DIFFERS BY FAMILY COMPOSITION

Nearly 2.5 million single adults without children in California have no health insurance coverage of any type. They account for half of the 5 million uninsured nonelderly adults in the state (Exhibit 28), far more than their share of the nonelderly adult population. Another 13% of uninsured adults are married couples without children and 28% are married couples with children, somewhat less than their respective shares of the nonelderly adult population. Finally, one in 10 uninsured adults are single parents, more than their proportionate share.

Opportunities for both employment-based health insurance and for Medi-Cal coverage also vary depending upon family composition (Exhibit 29). One in three (32%) single adults is uninsured as a result of a moderate rate of

EXHIBIT 28. UNINSURED ADULTS BY FAMILY COMPOSITION, AGES 19-64, CALIFORNIA, 1999



Note: Numbers may not add to 100% due to rounding.
Source: March 2000 Current Population Survey

About half of uninsured non-elderly adults are single without children

job-based insurance (55%) and few opportunities for coverage through Medi-Cal (6%). Just 16% of married couples without children are uninsured — half the rate for single adults; married couples without children have higher rates of job-based insurance as a result of more opportunities to obtain dependent coverage but a low rate of Medi-Cal coverage. Married couples with children also have substantial opportunities to be covered as dependents, resulting in a relatively low uninsured rate despite less access to Medi-Cal. Single parents have few opportunities to obtain job-based insurance as dependents; their generally lower family incomes result in one in four depending on Medi-Cal coverage, but they still have a high rate of uninsurance (30%). Because adults' coverage varies so much by family composition, we will examine their coverage more closely.

EXHIBIT 29. HEALTH INSURANCE COVERAGE OF NONELDERLY ADULTS BY FAMILY COMPOSITION, AGES 19-64, CALIFORNIA, 1999

	SINGLE ADULT	MARRIED COUPLE WITHOUT CHILDREN	MARRIED COUPLE WITH CHILDREN	SINGLE PARENT
UNINSURED	32%	16%	19%	30%
JOB-BASED INSURANCE	55%	74%	69%	43%
PRIMARY ENROLLEE	45%	51%	41%	38%
DEPENDENT COVERAGE	10%	23%	28%	5%
PRIVATELY PURCHASED	5%	6%	5%	3%
MEDI-CAL	6%	2%	6%	24%
OTHER PUBLIC	2%	2%	<1%	<1%
TOTAL	100% (POPULATION: 7,798,000)	100% (POPULATION: 3,829,000)	100% (POPULATION: 7,238,000)	100% (POPULATION: 1,573,000)

Note: Numbers may not add to 100% due to rounding. Population estimate is based on March 2000 Current Population Survey, which may differ from population estimates derived from other sources.

Source: March 2000 Current Population Survey

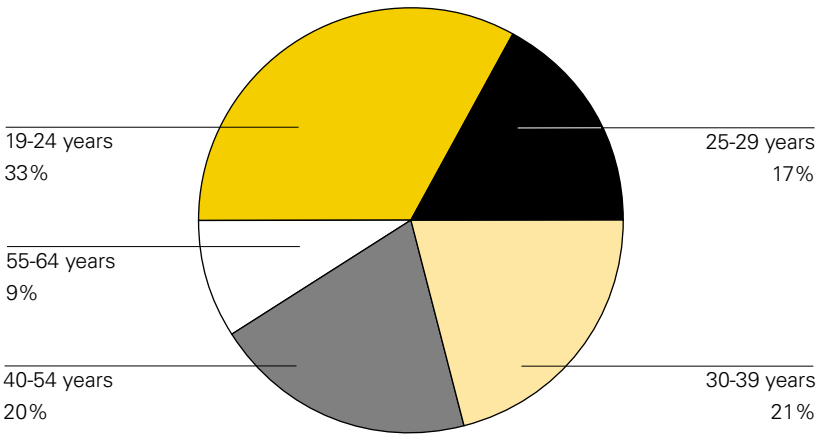
HEALTH INSURANCE COVERAGE OF SINGLE ADULTS

One third (33%) of uninsured single adults are 19-24 years of age, but three in 10 (29%) uninsured single adults are at least 40 years of age (Exhibit 30).

Among this young age group, 51% receive employment-based insurance, including 30% who are covered as a dependent (Exhibit 31). Those who are students may be covered by their parents' health benefits, but many have few options for health insurance coverage in entry-level jobs or as college students. If they are healthy, they may see little necessity to pay for health insurance when it is available to them through the private marketplace.

Many young uninsured adults do have health problems. The single adults who are at least 40 years of age are at even higher risk because they are at an age when chronic conditions are becoming more prevalent and the need for health care increases. Single adults are usually not eligible for Medi-Cal coverage, unless they are disabled or part of a family with dependent children. In the absence of eligibility for Medi-Cal or another program that is supported by federal matching funds, many single adults must rely on county health services, the state's County Medical Services Program, or charity care that serve the medically indigent. Disabling conditions may result in the increasing rates of Medi-Cal coverage that are evident among the older adults in this age group.

EXHIBIT 30. UNINSURED SINGLE ADULTS BY AGE GROUP, AGES 19-64, CALIFORNIA, 1999



Source: March 2000 Current Population Survey

EXHIBIT 31. HEALTH INSURANCE COVERAGE OF SINGLE ADULTS BY AGE GROUP, AGES 19-64, CALIFORNIA, 1999

	19-24 YRS	25-29 YRS	30-39 YRS	40-54 YRS	55-64 YRS
UNINSURED	39%	35%	32%	26%	23%
JOB-BASED INSURANCE	51%	55%	58%	58%	54%
PRIVATELY PURCHASED	3%	7%	4%	5%	9%
MEDI-CAL	4%	2%	5%	8%	9%
OTHER PUBLIC	2%	1%	1%	2%	6%
TOTAL	100%	100%	100%	100%	100%

Note: Numbers may not add to 100% due to rounding.
Source: March 2000 Current Population Survey

HEALTH INSURANCE COVERAGE OF MARRIED COUPLES WITHOUT CHILDREN

More than 600,000 of the uninsured are married couples without children. Only one in five (21%) of this group of uninsured residents is under 30 years of age, and more than one in three (35%) is 55-64 years of age.

Compared to single adults without children, married couples without children have higher rates of job-based insurance primarily because they have more access to coverage through a spouse. Within each age group (except the youngest), persons in married couples are about as likely as single adults to have health benefits in their own name, but those in married couples have the advantage of dependent coverage, which reduces their risk of being uninsured (Exhibit 32). (Because less than one in 20 persons in married couples is between 19 and 24 years of age, we have aggregated this age group with those ages 25-29.)

Married couples without children have the best advantage in securing job-based coverage

EXHIBIT 32. HEALTH INSURANCE COVERAGE OF MARRIED COUPLES WITHOUT CHILDREN BY AGE GROUP, AGES 19-64, CALIFORNIA, 1999

	19-29 YRS	30-39 YRS	40-54 YRS	55-64 YRS
UNINSURED	27%	20%	12%	17%
JOB-BASED INSURANCE	65%	70%	79%	72%
PRIMARY ENROLLEE	43%	55%	54%	50%
DEPENDENT COVERAGE	22%	15%	25%	22%
PRIVATELY PURCHASED	2%	6%	7%	6%
MEDI-CAL	2%	3%	1%	2%
OTHER PUBLIC	4%	1%	1%	3%
TOTAL	100%	100%	100%	100%

Note: Numbers may not add to 100% due to rounding.
Source: March 2000 Current Population Survey

HEALTH INSURANCE COVERAGE OF ADULTS WITH CHILDREN

The uninsured include nearly 1.4 million adults who are married couples with children. In each age group, the probability of receiving employment-based insurance as a dependent is about the same, but the risk of being uninsured decreases with increasing age as the probability of receiving job-based insurance in one's own name increases (Exhibit 33).

Among working families, adults who are married and have children have lower average incomes than is true for adults who are married but have no children. Only 14% of married couples without children have family incomes below 250% of poverty, compared to 38% of married couples with children.

EXHIBIT 33. HEALTH INSURANCE COVERAGE OF MARRIED COUPLES WITH CHILDREN BY AGE GROUP, AGES 19-64, CALIFORNIA, 1999

	19-29 YRS	30-39 YRS	40-54 YRS	55-64 YRS
UNINSURED	32%	20%	14%	11%
JOB-BASED INSURANCE	54%	70%	74%	77%
PRIMARY ENROLLEE	28%	41%	47%	49%
DEPENDENT COVERAGE	26%	29%	28%	29%
PRIVATELY PURCHASED	2%	5%	7%	2%
MEDI-CAL	10%	5%	5%	8%
OTHER PUBLIC	1%	1%	<1%	1%
TOTAL	100%	100%	100%	100%

Note: Numbers may not add to 100% due to rounding.
Source: March 2000 Current Population Survey

Among working families, married adults who are parents have lower average incomes than married adults without children

EXHIBIT 34. HEALTH INSURANCE COVERAGE OF SINGLE PARENTS WITH CHILDREN BY AGE GROUP, AGES 19-64, CALIFORNIA, 1999

	19-29 YRS	30-39 YRS	40-54 YRS	55-64 YRS
UNINSURED	35%	29%	25%	38%
JOB-BASED INSURANCE	29%	47%	50%	47%
PRIVATELY PURCHASED	1%	3%	3%	6%
MEDI-CAL	34%	20%	21%	10%
OTHER PUBLIC	<1%	1%	<1%	<1%
TOTAL	100%	100%	100%	100%

Note: Numbers may not add to 100% due to rounding.
Source: March 2000 Current Population Survey

HEALTH INSURANCE COVERAGE OF SINGLE PARENTS

Three in 10 single parents — 472,000 adults — are uninsured (Exhibit 34). Single parents face constraints on obtaining employment-based health insurance that are similar to those of single adults without children. They have similar rates of labor force participation (a little more than four in every five are working), and among those who work full-time, full-year as employees, similarly high proportions have health benefits in their own name. But their probability of receiving job-based insurance is lower overall than for adults in married couples because they lack the opportunity of having an employed spouse.

However, they are better protected by Medi-Cal than any other group of adults (Exhibit 34), particularly at younger ages when their children are more likely to be young. Medi-Cal coverage declines in the middle years, as children grow out of their eligibility for the program.

Single parents have high uninsured rates but are protected by Medi-Cal

EXHIBIT 35. HEALTH INSURANCE COVERAGE OF NONELDERLY ADULTS BY WORK STATUS, AGES 19-64, CALIFORNIA, 1999

	FULL-TIME FULL-YEAR	FULL-TIME PART-YEAR	PART-TIME	NOT WORKING OUTSIDE THE HOME
UNINSURED	19%	29%	30%	33%
JOB-BASED INSURANCE	75%	57%	55%	38%
PRIMARY ENROLLEE	64%	38%	21%	—
DEPENDENT COVERAGE	11%	19%	34%	—
PRIVATELY PURCHASED	4%	4%	8%	6%
MEDI-CAL	2%	8%	6%	19%
OTHER PUBLIC	<1%	2%	2%	4%
TOTAL	100% (POPULATION: 11,180,000)	100% (POPULATION: 2,581,000)	100% (POPULATION: 2,692,000)	100% (POPULATION: 3,985,000)

Note: Numbers may not add to 100% due to rounding. Population estimate is based on March 2000 Current Population Survey, which may differ from population estimates derived from other sources.

Source: March 2000 Current Population Survey

HEALTH INSURANCE COVERAGE OF WORKING AND NONWORKING ADULTS

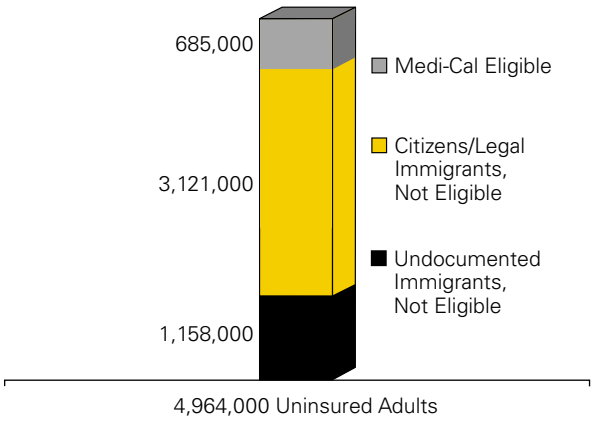
As might be expected, full-time, full-year workers are the most likely to receive job-based insurance and the least likely to be uninsured (Exhibit 35). Nevertheless, nearly one in five remains without coverage — accounting for more than four in 10 (43%) of all uninsured nonelderly adults. Nearly two-thirds of full-time, full-year workers receive health benefits in their own name, and another 11% obtain it as a dependent rather than through their own job. This latter group reflects a cost shift from one employer, who avoids paying for the worker's health insurance, to another employer, who is likely to bear part of the cost of family coverage.

Adults who are working full time but for less than the full year and part-time workers both have similar rates of employment-based health insurance. Full-time, part-year workers, however, are more likely to be covered in their own name, while part-time workers are more likely to depend on a spouse's employment for their coverage. Both groups have high rates of uninsurance — about three in 10.

Those who are not working outside the home are, of course, least likely to receive employment-based health insurance and most likely to be uninsured, despite their higher rate of Medi-Cal coverage (Exhibit 35).

Even among adults who work full-time/full-year, one in five remains uninsured

EXHIBIT 36. UNINSURED ADULTS BY ELIGIBILITY FOR MEDI-CAL AND HEALTHY FAMILIES, AGES 19-64, CALIFORNIA, 2000



Source: Estimates of eligibility calculated by the UCLA Center for Health Policy Research based on data from the March 2000 Current Population Survey

UNINSURED ADULTS ELIGIBLE FOR MEDI-CAL COVERAGE

Children are not the only group who could benefit from intensified outreach and enrollment efforts for Medi-Cal. We estimate that 685,000 nonelderly adults (range: 595,000 to 775,000) are uninsured but eligible for Medi-Cal coverage, 14% of the nearly 5 million uninsured adults in the state (Exhibit 36).

About seven in 10 of these eligible uninsured adults are workers or in families headed by a worker — truly the working poor whose earnings fall well within Medi-Cal's very stringent income limits for adults. Nearly four in 10 eligible uninsured adults are full-time employees or in families headed by at least one full-time employee, and another three in 10 are part-time employees or self-employed workers or their spouses. The final three in 10 uninsured adults who are eligible for Medi-Cal are in nonworking families.

About six in 10 eligible uninsured adults are in families with dependent children, the working poor and families that are not in the labor force. The remainder are adults without children, primarily disabled adults or those caring for disabled adults.

Another 3.1 million uninsured adults are citizens or legal immigrants who do not qualify for Medi-Cal (Exhibit 36). More than half are single adults, who are eligible for

685,000 adults are uninsured but eligible for Medi-Cal coverage

few state and federal programs to assist them with their medical expenses. However, nearly 450,000 have family incomes below poverty — that is, less than $8,667 for a single adult or $11,214 for a married couple. Another 1.3 million uninsured adults are citizens or legal immigrants who are near poor, with family incomes between 100% and 249% of poverty — less than $21,668 for a single adult or $28,103 for a couple. At these income levels, it is unlikely that adults would find health insurance coverage affordable without substantial contributions from employer and/or government.

Finally, approximately 1.1 million uninsured adults are undocumented immigrants. Although they are not eligible for Medi-Cal or Healthy Families, many are in mixed-status families with children who are often U.S.-born citizens and spouses who may be legal immigrants or citizens. Medical care for any family member, particularly when that family member is the primary breadwinner, is important to all family members. Yet this is a very low-income population: 85% have family incomes below 250% of the poverty level, including 35% with incomes below poverty. In Part 5, we examine Governor Gray Davis's proposed expansion of the Healthy Families Program to parents of eligible children and offer recommendations for options to cover more of California's 5 million uninsured adults.

In sum, we found similar patterns of vulnerability among adults in securing coverage that was found for the nonelderly overall. Young adults, the poor and near poor, and Latinos all have high uninsured rates. We also examined coverage by family composition and found that single adults without children have the highest uninsured rates and few public coverage options. Finally, even among full-time, full-year workers, one in five has not secured job-based coverage. In the next section, Part 4, we explore job-based coverage in more detail.

4. EMPLOYMENT-BASED HEALTH INSURANCE: TRENDS AND FUTURE PROSPECTS

4

Most Americans under the age of 65 receive their health insurance coverage through employment — either from their own jobs, or from those of family members. Because job-based insurance constitutes about 80% of coverage among the insured nonelderly population, it is critical that we understand this source of coverage and Californians' access to it. Given the recent declines in Medicaid coverage and the fact that private individual insurance coverage rates are low and stable, trends in uninsurance rates are determined, in large measure, by changes in job-based coverage rates.

The good news is that job-based coverage is on the rise, both in California and nationally. As shown earlier in Exhibit 3, rates for Californians increased from 56.4% to 60.6% from 1994 to 1999 among the nonelderly population. These aggregate numbers, however, often mask key underlying differences. In Part 4 we examine employment-based insurance coverage among the nonelderly population ages 19-64. We seek answers to several questions:

- What trends to do we see in job-based coverage rates for different population groups over time?
- How great of a difference is there between job-based coverage in California and the United States as a whole? Is any such difference greater for some population groups than for others? To what extent are these differences the result of differing population characteristics vs. structural factors, such as the labor market?
- How important is firm size as a factor in determining job-based coverage?
- Are the recent increases in job-based coverage in California primarily the result of more workers being covered, or alternatively, more of their dependents obtaining coverage?
- How has job-based coverage changed as a result of changes in the proportion of employers offering coverage, employees' eligibility for such coverage, and workers and their families enrolling in coverage for which they are eligible?
- How affordable is employment-based insurance coverage to the groups of workers who are most likely not to have it?
- How will economic trends affect employment-based health insurance coverage in future years?

The remainder of Part 4 is divided into four sections. The first section examines adults' job-based coverage in California and the United States in 1999. The second section provides trends in these rates over time. These sections rely on the March 1995-2000 Current Population Surveys, which asks respondents about their coverage during the previous calendar years (e.g., the March 2000 CPS data apply to coverage in 1999). The third section focuses on the extent to which employers offer job-based coverage, as well as the extent to which employees are eligible for it and accept it. This section uses data from employees that are included in the February 1995, 1997, and 1999 Current Population Surveys. Unlike the March CPS, the February survey asks respondents about their experience in the current rather than previous year. The final section provides further discussion of the factors responsible for California's lower

(but improving) job-based coverage, and discusses how economic trends may affect job-based health insurance coverage in future years.

JOB-BASED COVERAGE IN 1999

As is evident in Exhibit 37, and as was discussed in some depth in Part 3, California adults experience large disparities in job-based insurance based on their ability to make demands in the labor market. The groups with the lowest job-based coverage rates include Latinos, those with low incomes, persons with low educational attainment, noncitizens, single individuals (especially those with children), adults under the age of 30, and those who do not work full-time all year.

The second column of Exhibit 37 shows job-based coverage rates in the United States for the same characteristics. Overall in 1999, 62.8% of Californians ages 19-64 had job-based health insurance coverage, considerably lower than the 69.4% figure for the nation as a whole. Many factors account for this 6.6 percentage-point difference.

Among nearly every population group, coverage rates for those in California are lower than for the country as a whole (with the single exception of African Americans, which could be the result of their small sample size in California). For example, 34% of Californians who did not graduate from high school had job-based coverage in 1999, compared to 39% nationally, while 73% of Californians who attended college received job-based insurance, compared to 78% in the nation as a whole. Some of the largest California-U.S. differences in job-based coverage are found among people whose incomes are between 100% and 249% of the poverty level: 43% in California vs. 52% for the United States as a whole.

Several other notable differences can also be detected in comparing the two columns of Exhibit 37. Californians with children tend to have much lower job-based coverage rates than their counterparts nationally. Single Californians with children have rates 7 percentage points lower than in the nation as a whole, and married Californians with children have rates 10 percentage points lower. The differences between California and the United States for those without children are only half as large.

Age also shows a distinct pattern although differences were not statistically significant. Whereas among those ages 55-64, job-based coverage rates are only 2 percentage points lower in California, the gap is much wider for all younger cohorts. In fact, that gap is at least 8 percentage points for all groups below 40 years of age.

Even among full-time, full-year workers, a smaller proportion of Californians have job-based insurance: 75% vs. 81%. And, across the major industry groups, California generally lags behind the national average in job-based insurance. The gap is considerable for certain industries such as manufacturing of non-durable goods (16%), retail trade (8%), personal services (7%) and agriculture/forestry/fishing (5%).

Many factors contribute to the fact that Californians are less likely than other Americans to obtain health insurance coverage through employment. Some are discussed here, and others later in this part of the report, when we compare offer, eligibility, and take-up rates in California those in the nation as a whole. These factors include:

- Latinos are much less likely than other racial and ethnic groups to have job-based coverage, and California has far

Economically vulnerable groups of Californians are far less likely to have job-based health insurance coverage

Californians lag behind the U.S. in job-based health insurance coverage

EXHIBIT 37. PERCENTAGE WITH JOB-BASED HEALTH INSURANCE COVERAGE, AGES 19-64, CALIFORNIA AND U.S., 1999

AGE	CALIFORNIA	U.S.	FAMILY INCOME	CALIFORNIA	U.S.
19-24 YEARS	48%	57%	LESS THAN 100% OF POVERTY	18%	21%
25-29 YEARS	56%	64%	100%-249% OF POVERTY	43%	52%
30-39 YEARS	64%	72%	250%-399% OF POVERTY	70%	76%
40-54 YEARS	69%	75%	400% OR MORE OF POVERTY	83%	86%
55-64 YEARS	65%	67%			
RACE/ETHNIC GROUP			**FAMILY COMPOSITION**		
NON-LATINO WHITE	72%	75%	SINGLE ADULT	55%	59%
LATINO	45%	47%	SINGLE PARENT	43%	50%
ASIAN AMERICAN/PACIFIC ISLANDER	64%	66%	MARRIED WITHOUT CHILDREN	74%	77%
AFRICAN AMERICAN	61%	58%	MARRIED WITH CHILDREN	69%	79%
CITIZENSHIP STATUS			**WORK EXPERIENCE**		
U.S.-BORN CITIZEN	70%	72%	FULL-TIME, FULL-YEAR	75%	81%
NATURALIZED CITIZEN	63%	65%	FULL-TIME, PART-YEAR	57%	61%
NONCITIZEN	40%	44%	PART-TIME	55%	62%
EDUCATIONAL ATTAINMENT			**SELECTED INDUSTRIES**		
LESS THAN HIGH SCHOOL GRADUATE	34%	39%	AGRIC./FORESTRY/FISHING	41%	46%
HIGH SCHOOL GRADUATE	60%	66%	MANUFACTURING OF NON-DURABLE GOODS	66%	82%
SOME COLLEGE	73%	78%	RETAIL TRADE	54%	62%
			PERSONAL SERVICES	47%	54%

Source: March 2000 Current Population Survey

more Latinos than most other states. They constitute 28% of the state's population, compared to just 11% nationally.

- Low- and moderate-income persons are far less likely to receive employment-based health benefits, and California has more low- and moderate-income individuals and families than the national average: 37% of Californians have incomes below 250% of the poverty level, compared to the national average of 33%.
- Those without a high school diploma are much less likely to have job-based coverage, and Californians are more likely (18%) than Americans overall (13%) to lack a high school diploma.
- A large proportion of noncitizens do not have job-based health insurance, and California has a much greater proportion of citizens (22%) than nationally (9%).

These factors help account for California's lower prevalence of job-based coverage, but they do not tell the whole story. This is because these factors may interact with each other

Latinos are far less likely to have job-based coverage, and they comprise 28% of the California population, compared to 11% nationally

and with factors in the economic, political, and social environment. Latinos, in particular, are more likely to possess several socio-demographic and labor market traits associated with lower job-based coverage. Compared to whites, they are less likely to have graduated from high school, to have jobs categorized as professional or managerial, and to be citizens, but they are more likely to have low incomes and work in the agricultural sector.

Sample-size limitations preclude us from examining job-based coverage rates for highly specific segments of the population (e.g., Latino agricultural workers below the poverty level). To analyze how the various differences in socio-demographic and labor market characteristics between California and the United States affect differences in job-based coverage, it is necessary to conduct a multivariate analysis.

Paul Fronstin of the Employee Benefit Research Institute has used data from the March 1999 Current Population Survey, reflecting coverage in 1998, to estimate the importance of each of the factors responsible for the California-U.S. differences in uninsurance rates.[29] Although the specific set of factors that affect uninsurance are likely to be somewhat different from the set of factors affecting job-based coverage, they do provide a good first approximation since the major driver in uninsurance is the lack of employer health insurance coverage. Fronstin's model "explains" 81% of the difference in uninsurance rates between California and the nation. He found that, controlling for all other factors, by far the greatest reason for California's higher uninsurance rates was differences in the racial/ethnic composition of the two populations (51% of the difference), particularly more Latinos in California. Other factors explaining part of the remaining difference are education (8%), firm size (8%), marital status (6%), industry (3%), age (3%), hours of work (2%), gender (1%), and wages (-2%; that is, with other factors in the model, wages were an ameliorating effect).

Fronstin further examined the factors that account for why Latino workers in California have a higher uninsurance rate than Latino workers in the nation. In his model, which he found accounted for 97% of the difference, citizenship "explained" nearly half the difference (47%), followed by education (16%), and firm size (15%), with wages, industry, hours of work, and demographic characteristics each accounting for less than 10%.

But why, when other factors are held constant, should being a Latino noncitizen result in a lower probability of having job-based insurance? Are Latino noncitizens less likely than citizens to obtain health insurance for cultural reasons? Or are there structural factors that reduce Latino noncitizens' access to job-based insurance?

Our data on the extent to which workers are offered health benefits by their employers suggest that California's Latinos and noncitizens are much less likely to work for an employer that offers health benefits at all. When their employer offers health benefits, however, they are about as likely as other workers to be eligible and to accept the benefits. Thus, our analysis points to structural factors in the labor market that either channel Latino noncitizen workers into jobs that do not offer health benefits, or that allow or encourage certain types of employers to hire Latino noncitizens and not provide health benefits. The specific

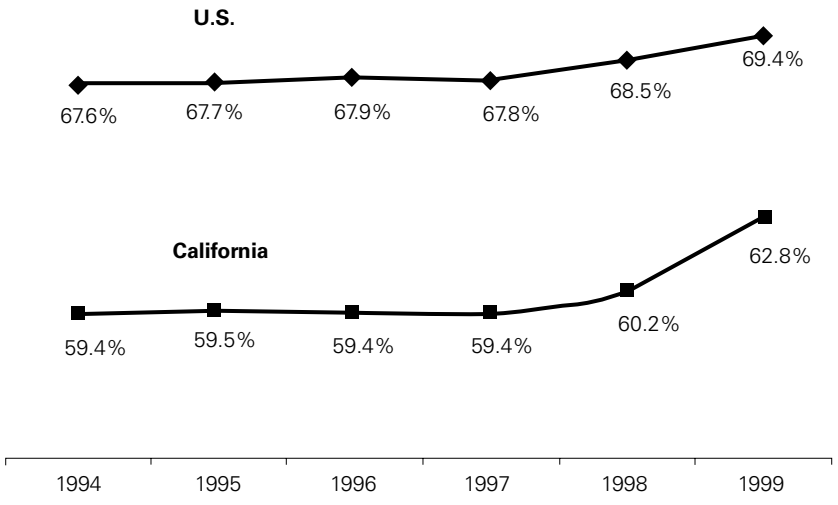
29 Fronstin P, Health Insurance Coverage and the Job Market in California, EBRI Special Report SR 36, Washington, DC: Employee Benefit Research Institute, September 2000.

factors that contribute to this pattern are important to understand because they lead to different policy options to ameliorate the problem — a point to which we will return shortly.

CHANGES IN JOB-BASED COVERAGE, 1994-1999

As Exhibit 38 shows, overall job-based coverage rates were lower among nonelderly adults in California than nationally from 1994 through 1999, with very little change until the last year despite the rapid and sustained economic growth. Coverage rates varied by no more than 0.3 percentage points nationally and 0.1 percentage points in California between 1994 and 1997, and then rose by 0.7 percentage points and 0.8 percentage points, respectively, in 1998. Between 1998 and 1999, however, California, pushed by strong economic growth, showed a larger increase than the country as a whole, with coverage rates rising 2.6 percentage points in California and only 0.9 percentage points nationally. The major pattern in the exhibit, however, is the stability of the California-U.S. difference over time; the job-based coverage gap was 8.2 percentage points in 1994 and 8.3 percentage points four years later, before shrinking somewhat in 1999. As discussed at the end of this part of the report, it is unclear whether this very recent relative improvement in California will persist, especially when the state is faced with future economic downturns.

EXHIBIT 38. JOB-BASED HEALTH INSURANCE COVERAGE RATES, AGES 19-64, CALIFORNIA AND U.S., 1994-1999



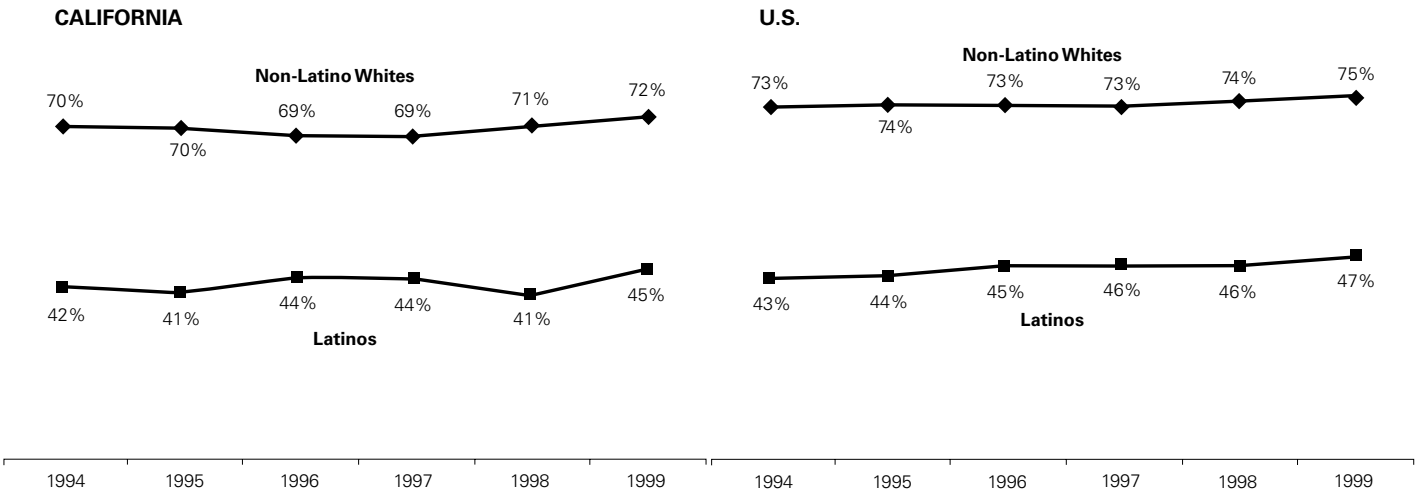
Source: March 1995, 1996, 1997, 1998, 1999, and 2000 Current Population Surveys

California and the U.S. show similar trends over time in job-based coverage

Economically disadvantaged Californians show the most improvement in coverage

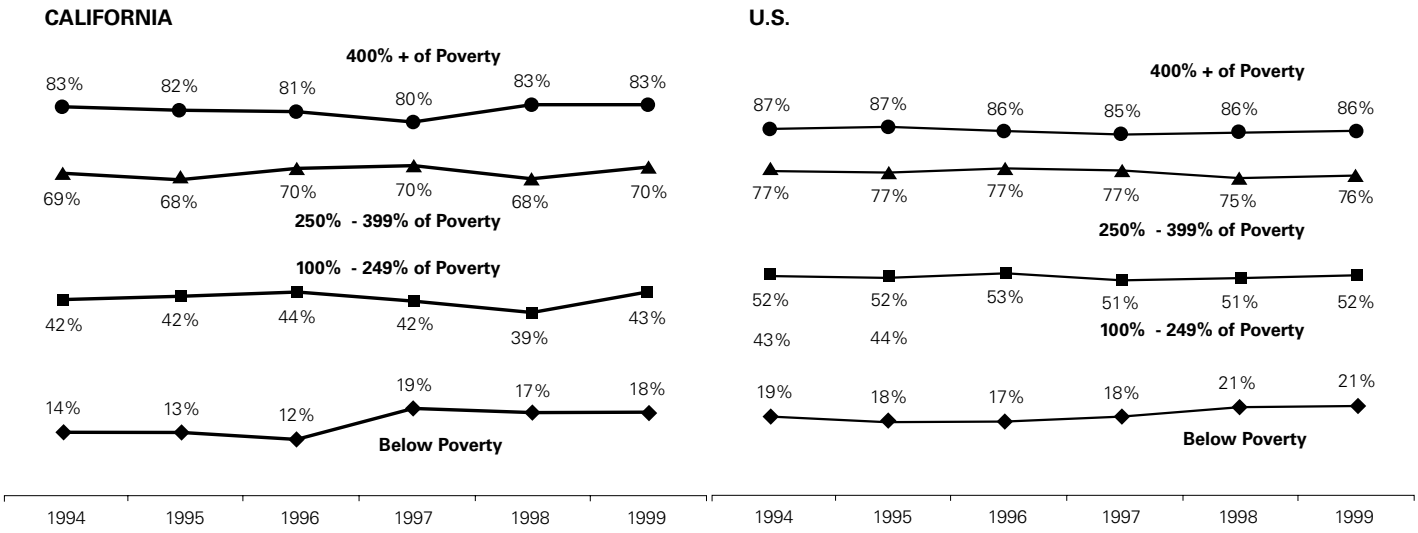
In the following sets of graphs, we compare changes in job-based coverage in California and the United States among different subgroups of the population between 1994 and 1999. For brevity, we focus on characteristics that highlight how Californians fared compared to those in the United States as a whole. Exhibit 39 shows changes for Latinos and non-Latino whites in California and the United States, respectively. (African Americans and Asian American/Pacific Islanders are not included because their sample sizes in California make the estimates very imprecise and unstable.) Although California's rates were slightly below those of the U.S. throughout the study period, both Latinos and non-Latino whites showed modest improvements in job-based coverage rates between 1994 and 1999. From 1994 to 1998, rates for California Latinos fluctuated, but then rose considerably — by 4 percentage points — between 1998 and 1999, as the labor market continued to improve. (The changes over time in California were not statistically significant, due to smaller sample sizes.) Job-based coverage rates among adults below the poverty level rose 4 percentage points in California and 2 percentage points in the United States (Exhibit 40). The main pattern of note is the persistently much higher rates of job-based coverage in the United States (averaging 52%) than in California (averaging 42%).

EXHIBIT 39. JOB-BASED HEALTH INSURANCE COVERAGE RATES BY RACE/ETHNIC GROUP, AGES 19-64, CALIFORNIA AND U.S., 1994-1999



Source: March 1995, 1996, 1997, 1998, 1999, and 2000 Current Population Surveys

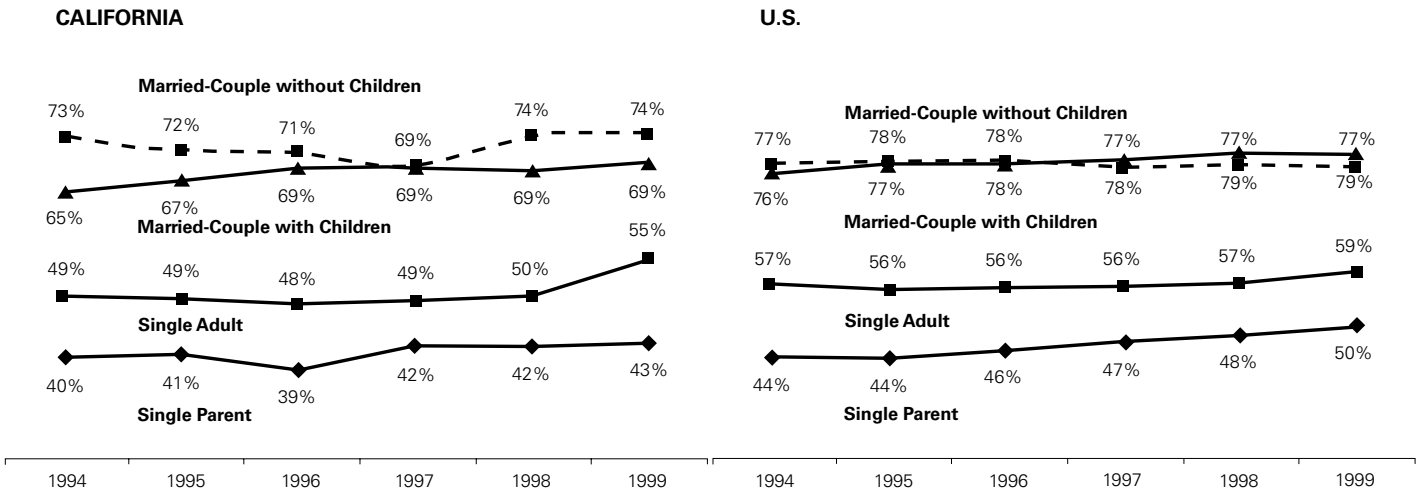
EXHIBIT 40. JOB-BASED HEALTH INSURANCE COVERAGE RATES BY FAMILY INCOME AS A PERCENTAGE OF POVERTY LEVEL, AGES 19-64, CALIFORNIA AND U.S., 1994-1999



Source: March 1995, 1996, 1997, 1998, 1999 and 2000 Current Population Surveys

Single adults without children experienced some of the greatest relative improvement in California (Exhibit 41). Job-based coverage rates rose from 49% to 55% (including a dramatic increase of 5 percentage points between 1998 and 1999), compared to a much smaller rise in the United States (57% to 59%). This improvement was seen for single adults in nearly every population group. Curiously, though, the same pattern did not occur for single parents, where rates increased by less in California (3 percentage points) than the nation as a whole (6 percentage points). This difference, however, was not statistically significant. In general, rates for married individuals rose very modestly over the study period.

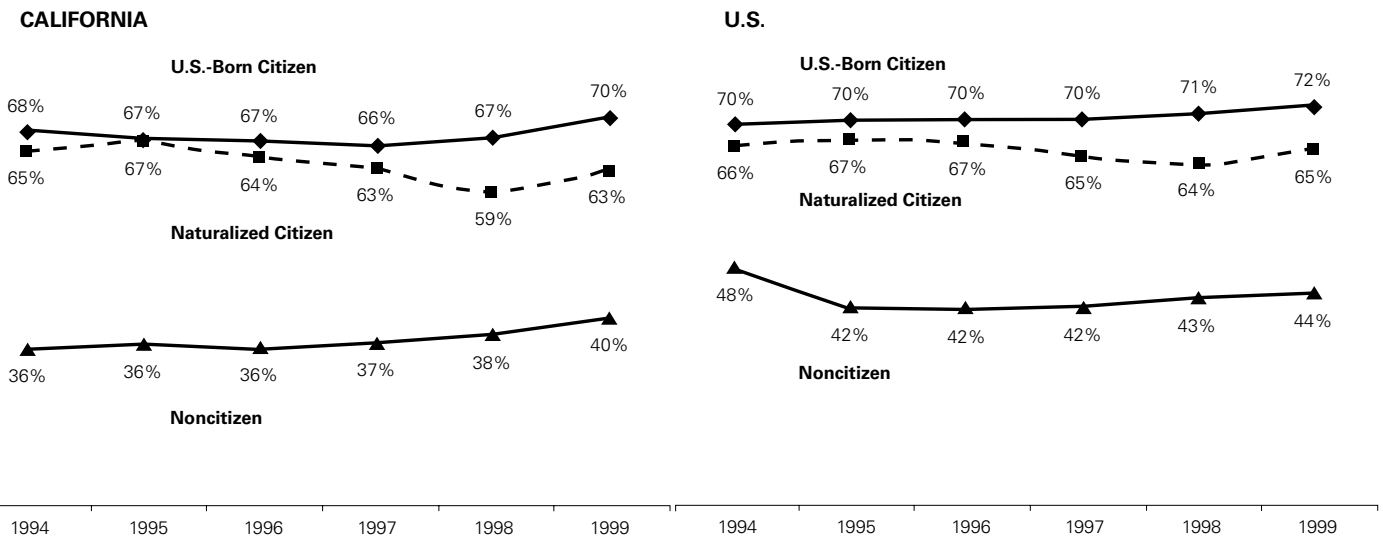
EXHIBIT 41. JOB-BASED HEALTH INSURANCE COVERAGE RATES BY FAMILY COMPOSITION, AGES 19-64, CALIFORNIA AND U.S., 1994-1999



Source: March 1995, 1996, 1997, 1998, 1999, and 2000 Current Population Surveys

Part-time and part-year workers experienced a greater (although not statistically significant) increase in job-based coverage in California than in the nation over the study period. In the case of part-time employees, coverage rates rose from 51% to 55%, compared to just a 2 percentage-point increase for the country as a whole. This may reflect the increasingly competitive nature of the job market in California during this period of economic recovery, manifested, in part, by somewhat more firms feeling the pressure to provide health insurance to part-time workers. (Data not shown.)

EXHIBIT 42. JOB-BASED HEALTH INSURANCE COVERAGE RATES BY CITIZENSHIP STATUS, AGES 19-64, CALIFORNIA AND U.S., 1994-1999



Source: March 1995, 1996, 1997, 1998, 1999, and 2000 Current Population Surveys

Finally, and perhaps most interesting of all, is the increase in job-based coverage in California among noncitizens — which contrasts with a more steady pattern in the nation as a whole (Exhibit 42). Between 1994 and 1999, employer coverage increased from 36% to 40% in California. Half of the change occurred from 1994 to 1998, and the other half in the last year. Rates in the United States declined from 1994 to 1995 and then remained stable. Again, California's economic growth was the main reason for the increase in job-based coverage among noncitizens.

EXHIBIT 43. PRIMARY AND DEPENDENT JOB-BASED HEALTH INSURANCE COVERAGE, AGES 19-64, CALIFORNIA AND U.S., 1994-1999

	1994	1995	1996	1997	1998	1999	CHANGE 1994-1999
CALIFORNIA							
JOB-BASED INSURANCE	59.5%	59.5%	59.4%	59.4%	60.2%	62.8%	+3.3*
PRIMARY	42.8%	42.5%	42.1%	42.4%	43.2%	44.5%	+1.7*
DEPENDENT	16.7%	17.0%	17.3%	17.0%	17.0%	18.3%	+1.6*
UNITED STATES							
JOB-BASED INSURANCE	67.6%	67.7%	67.9%	67.8%	68.5%	69.4%	+1.8*
PRIMARY	47.7%	47.9%	48.0%	47.9%	48.4%	48.6%	+0.9*
DEPENDENT	19.9%	19.8%	19.9%	19.9%	20.1%	20.8%	+0.9*

* Change is statistically significant at $p \leq .05$.

Source: March 1995, 1996, 1997, 1998, 1999 and 2000 Current Population Surveys

Primary vs. Dependent Coverage

We can also examine whether employment-based health insurance is obtained as primary coverage, in which the worker enrolls in his or her employer's health plan, or alternatively, whether it is dependent coverage, which is obtained through another family member's work. When primary coverage of the adult population increases over time, it is often an indication of a tight labor market, in which employers feel the need to hire more workers or increase the hours of work of existing employees, thus making more adults eligible for primary coverage. In a competitive labor market, employers may also compete for employees by offering coverage or making it more affordable for workers, thus improving access to health benefits for their employees.

Increases in dependent coverage can result from the same labor market conditions, as more adults have access to job-based insurance through a working spouse, employers pick up a larger portion of the often considerable share of premiums required by most employers for family coverage, or families having more total income, which can make premiums seem more affordable. Rising dependent coverage also could indicate that more working individuals are choosing to obtain their health insurance from a spouse's employer rather than their own.

Exhibit 43 shows overall trends in primary and dependent coverage in California and the United States as a whole between 1994 and 1999. To interpret the exhibit, consider the 1999 California data. The exhibit indicates that 62.8% of Californians age 19-64 have job-based coverage, including 44.5% who have it through their own job, and another 18.3% who obtained it through a family member's job. The trends, not surprisingly, mimic those presented in Exhibit 38, where rates in both California and the nation were steady through 1997, and then rose in 1998 and 1999. Primary and dependent coverage were equally responsible for the increase in job-based coverage. In California, for example, 1.7 percentage points of the 3.3 percentage-point increase over the five-year period was in primary coverage, and 1.6 in dependent coverage.

EXHIBIT 44. CHANGE IN PRIMARY AND DEPENDENT JOB-BASED HEALTH INSURANCE COVERAGE BY SELECTED SOCIO-DEMOGRAPHIC AND JOB CHARACTERISTICS, AGES 19-64, CALIFORNIA, 1994-1999

	1994	1999	CHANGE 1994-1999
LATINOS			
JOB-BASED INSURANCE	42.0%	45.2%	+3.2**
PRIMARY	28.8%	31.0%	+2.2
DEPENDENT	13.2%	14.2%	+1.0
INCOME 100%-249%			
OF POVERTY LEVEL			
JOB-BASED INSURANCE	41.6%	43.3%	+1.7
PRIMARY	29.0%	28.5%	–0.5
DEPENDENT	12.6%	14.8%	+2.2
SINGLE PARENT			
JOB-BASED INSURANCE	40.5%	42.6%	+2.1
PRIMARY	36.6%	37.7%	+1.1
DEPENDENT	3.9%	4.9%	+1.0
NONCITIZENS			
JOB-BASED INSURANCE	35.6%	40.2%	+4.6*
PRIMARY	24.0%	27.0%	+3.0*
DEPENDENT	11.6%	13.2%	+1.6
PART-TIME WORKERS			
JOB-BASED INSURANCE	51.0%	54.8%	+3.8
PRIMARY	21.2%	21.4%	+0.2
DEPENDENT	29.8%	33.4%	+3.6
RETAIL TRADE			
JOB-BASED INSURANCE	55.4%	53.6%	–1.8
PRIMARY	35.6%	33.4%	–2.2
DEPENDENT	19.8%	20.2%	+0.4

* Change is statistically significant at $p \leq 0.05$.

** Change is statistically significant at $p \leq 0.06$.

Source: March 1995 and 2000 Current Population Surveys

To further understand these changes for some of the more economically vulnerable groups, we compared how much primary and dependent coverage rose or fell from 1994 to 1999. With the exception of overall job-based and primary coverage among noncitizens, and overall job-based among Latinos, none of the differences discussed here reached statistical significance, but the patterns are nevertheless noteworthy. These figures are shown in Exhibit 44. For certain groups, most of the increase in job-based insurance was due to higher rates of primary coverage. Among Latinos, primary coverage rose by 2.2 percentage points, but dependent coverage by only 1.0 percentage point. Among noncitizens, primary coverage significantly increased 3.0 percentage points, compared to 1.6 percentage points for dependent coverage. These increases in primary coverage are indicative of the employment gains of California's strong economy. The fact that dependent coverage did not rise as quickly, however, most likely is because of workers' difficulties in affording the costs associated with this coverage.

A different pattern emerged for those with family incomes between 100% and 249% of the poverty level.[30] Primary coverage remained essentially unchanged from 1994 to 1999, but dependent coverage rose by 2.2 percentage points (Exhibit 44). This pattern is difficult to explain. One possibility is that over time, more low-income working couples are becoming more sophisticated in obtaining dependent coverage when only one of their employers provides health insurance, but the changes for this group are not statistically significant and may be due merely to sampling variation.

The exhibit also shows that dependent coverage increased more quickly than primary coverage among part-time workers. Among part-time workers, the differences were especially great, with dependent coverage increasing by 3.6 percentage points, compared to only 0.2 percentage points for primary coverage. It is not terribly surprising that part-time workers would obtain their health insurance coverage as dependents, suggesting that families were improving their employment and earnings in the strong labor market.

We look at the retail trade industry, which comprises a large proportion (13.4%), of California's economy and which also has low coverage rates. We find that for this sector, primary coverage decreased from 35.6% to 33.4% while dependent coverage was flat. Retail trade includes restaurants, gasoline service stations, and grocery stores. Many of the workers in this sector are self-employed or part-time workers and thus face prohibitive cost and/or eligibility requirements in obtaining health insurance. Finally, it should be noted that although there were some interesting patterns in dependent and primary care coverage between 1994 and 1999, most of California's economically vulnerable groups — with the exception of Latino and noncitizen employees and their families — experienced no statistically significant improvement in job-based coverage during this period.

30 We do not examine those with incomes below the poverty level because job-based coverage is relatively infrequent among this group.

EXHIBIT 45. PRIMARY AND DEPENDENT JOB-BASED HEALTH INSURANCE COVERAGE OF ADULTS BY FIRM SIZE, AGES 19-64, CALIFORNIA AND U.S., 1994 AND 1999

	CALIFORNIA		U.S.		DIFFERENCE BETWEEN CALIFORNIA AND U.S.**	
FIRM SIZE	**1994**	**1999**	**1994**	**1999**	**1994**	**1999**
<10 WORKERS						
JOB-BASED INSURANCE	41.3%	43.4%	51.0%	52.6%	–9.7*	–9.2*
PRIMARY	20.0%	22.0%	24.8%	25.6%	–4.8*	–3.6*
DEPENDENT	21.3%	21.4%	26.2%	27.0%	–4.9*	–5.6*
10-24 WORKERS						
JOB-BASED INSURANCE	52.8%	59.6%	62.2%	66.3%	–9.4*	–6.7*
PRIMARY	37.7%	42.8%	39.5%	43.0%	–1.7	–0.2
DEPENDENT	15.1%	16.8%	22.7%	23.3%	–7.7*	–6.5*
25-99 WORKERS						
JOB-BASED INSURANCE	60.7%	67.4%	72.8%	74.2%	–12.1*	–6.8*
PRIMARY	47.1%	53.6%	55.1%	55.4%	–8.0*	–1.8
DEPENDENT	13.6%	13.8%	17.7%	18.8%	–4.1*	–5.0*
100-499 WORKERS						
JOB-BASED INSURANCE	75.2%	77.9%	80.9%	81.2%	–5.7*	–3.3*
PRIMARY	61.4%	63.1%	65.0%	65.2%	–3.6	–2.1
DEPENDENT	13.8%	14.8%	15.9%	16.0%	–2.1	–1.2
500+ WORKERS						
JOB-BASED INSURANCE	82.2%	80.9%	84.8%	84.6%	–2.6*	–3.7*
PRIMARY	70.0%	67.4%	71.1%	70.0%	–1.1	–2.5*
DEPENDENT	12.2%	13.5%	13.7%	14.6%	–1.5*	–1.1

* Change is statistically significant at $p \leq 0.05$.

** Negative number indicates California is lower than U.S. average; postive number indicates California is higher than U.S. average.

Source: March 1995 and 2000 Current Population Surveys

Differences in Job-Based Coverage Rates by Firm Size

One of the most important determinants of employer coverage is firm size. Exhibit 45 presents primary and dependent coverage for five firm size categories.[31] To interpret these data, consider Californians in firms with 500 or more workers in 1999. Nearly 81% of individuals ages 19-64 working in these large firms have job-based coverage. Of these, 67.4% enrolled in coverage provided by that employer, and 13.5% enrolled as dependents through family members' jobs. These family members could work for the same employer, another large employer, or a smaller employer that offers (for whatever reason) more attractive coverage.

Primary coverage is far lower in small firms than in large ones. In California in 1999, for example, only 22.0% of adult workers in firms with fewer than 10 workers had their own health benefits, compared to 42.8% in firms with 10-24 employees and 67.4% in firms with 500 or more employees.

California's workers are only slightly more likely than workers nationally to be employed in firms with fewer than 25 workers (25% vs. 23%, respectively). And they are less likely to be employed in medium to large firms with more than 100 employees (45% in California vs. 49% nationally), firms that traditionally offer health insurance. In addition, California workers in all firm-size categories received job-based coverage at lower rates in 1994 and 1999 (Exhibit 45).

The good news is that between 1994 and 1999, the primary coverage gap between California and the national average decreased for all firm sizes except the largest. The greatest relative gains were among employees of firms with 25-99 workers, possibly suggesting a policy impact of the small-group market insurance reforms during this period. However, among the largest firms (500+ employees), which account for the largest share of the work force, primary coverage declined in California and did so more rapidly than in the nation as a whole. Between 1994 and 1999, dependent coverage remained stable or increased in each firm-size group, but the U.S.-California gap widened for firms with fewer than 10 workers and those with 25-99 employees.

31 Firm size is reported in the CPS in discrete categories, such as fewer than 10 employees, 10-24, 25-99, 100-499, 500-999, and 1000 or more. We are, therefore, unable to specify groupings that may be more relevant to California policy, such as the cut-off point for small-group market insurance reform and insurance products like PacAdvantage and California Choice that cater to firms from 2 to 50 employees.

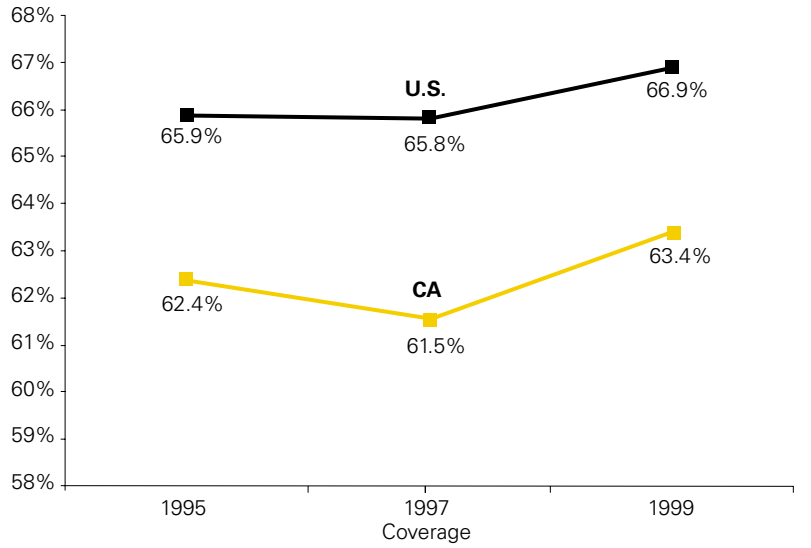
Californians in small firms are less likely to have coverage from an employer

THE COMPONENTS OF JOB-BASED COVERAGE

In the previous section, we compared how California differs from the United States as a whole in job-based health insurance for different groups over the last five years. In this section, we take a closer look at primary job-based coverage with a different source of data: the February Current Population Survey of the adult, nonelderly working population. We first look at the overall coverage rates, then examine the three components of coverage: 1) whether employers offer coverage to any employees who work for them — the "offer rate"; 2) whether employees are eligible for such coverage when it is offered in their firm — the "eligibility rate"; and 3) whether workers enroll in coverage for which they are eligible — the "take-up" rate. All of these components determine job-based coverage for the worker.[32]

Between 1997 and 1999, California's coverage rate rose faster than for the United States as a whole, but not enough to close the California-U.S. gap (Exhibit 46).[33] California's economic boom buoyed the rise in job-based coverage from 61.5% in 1997 to 63.4% in 1999, after a downturn between 1995 and 1997.

EXHIBIT 46. JOB-BASED HEALTH INSURANCE COVERAGE RATES OF EMPLOYEES, AGES 19-64, CALIFORNIA AND U.S., 1995, 1997, AND 1999



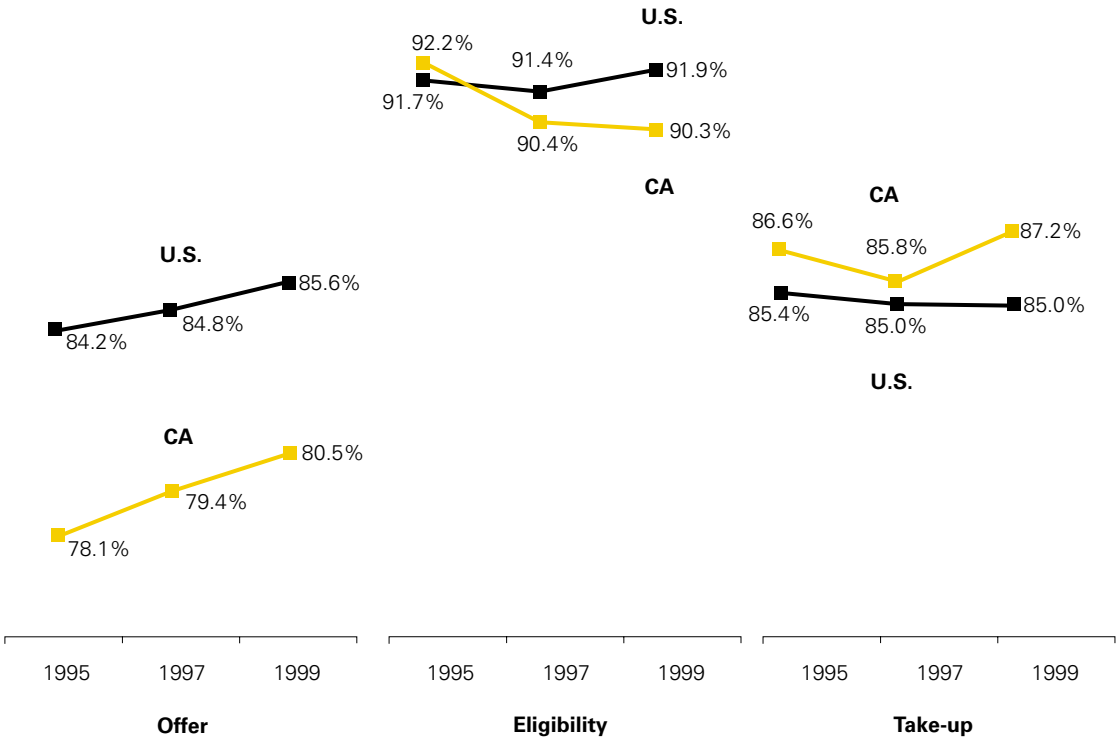
Source: February 1995, 1997, and 1999 Current Population Surveys

32 Coverage rates are a product of offer, eligibility and take-up rates so that (offer rate x eligibility rate x take-up rate) = coverage rate.

33 This California-U.S. gap based on employee reports of offer rates in the CPS is similar to data reported in surveys of employers. The National Employer Health Insurance Survey (NHEIS), 1993, reported that among private business establishments, California's job-based coverage (47%) was less than the nation's (51.6%). Source: National Center for Health Statistics. *Employer-Sponsored Health Insurance: State and National Estimates*. Hyattsville, MD, 1997.

California lags the nation in offer and eligibility rates, but take-up rates are higher

EXHIBIT 47. OFFER, ELIGIBILITY AND TAKE-UP RATES, EMPLOYEES AGES 19-64, CALIFORNIA AND U.S., 1995, 1997, AND 1999



Source: February 1995, 1997, and 1999 Current Population Surveys

To better understand this, we examine how offer rates, eligibility rates and take-up rates have changed in California and the nation, and we examine these changes by socio-demographic and employment characteristics. The biggest gap between California and the United States is in the offer rate (Exhibit 47). California's offer rates are much lower than for the nation (the left set of trend lines in Exhibit 47), but offer rates rose at a slightly faster rate in California than in the country as a whole from 1997 to 1999. This trend suggests the importance of economic growth expanding employment among firms that offer health benefits, or the consequences of a resulting tight labor market encouraging more employers to offer health benefits.

Eligibility rates (the middle portion of the chart) for both the state and the nation were high as a percentage of all workers whose employer offers coverage. However, the overall eligibility rate for California has declined over time, while the U.S. rate has remained relatively flat. This trend

Offer rates are lower for California's low-wage, low education workers

could be the consequence of employers tightening eligibility requirements with respect to hours, duration of employment, etc.

For the final component of coverage, the story is different. While California lags behind the nation in offer and eligibility, its take-up rates are higher. This trend could result from workers, who are employed in firms that offer coverage and who are eligible for such coverage, having more family income with which to pay their required shares of premiums. In the following sections we examine the trends in each component of job-based coverage, by socio-demographic and labor force groups, and compare California's trends with those of the United States as a whole.

Offer Rates by Socio-Demographic and Economic Characteristics

California's offer rate overall in 1999 was 5 percentage points lower than the national average.[34] Exhibits 48 and 49 show how offer rates differ for various groups by socio-demographic and labor-force characteristics. Offer rates were lower for California than for their counterparts nationally among Latinos, noncitizens, and across all age groups (Exhibit 48). While the offer rate among union members is much higher than among non-union members, it was not statistically different for union members in California compared to those in the nation as a whole in 1999, but it was lower in California among non-union members than in the United States (Exhibit 49). Even among permanent workers and full-time workers, California's offer rates were significantly lower than the nation's. Of great concern is the fact that California significantly lags behind the nation in offer rates for workers who have less than a high school education (–14.7 percentage points) and those who make less than $9.51 an hour (–14.3 percentage points).

Still, offer rates for California have risen from 78.1% in 1995 to 80.5% in 1999, with the greatest gains for younger workers (19-24 year olds), union members, and temporary workers. Yet despite this rise in offer rates from 1995 to 1999, the offer rates for lower-wage workers declined during this period, and the disparity between California and the national average did not significantly shrink. Also, while offer rates rose in certain sectors of the labor market, they were down for manufacturing of non-durable goods, which includes the garment and food industries, from 78.5% in 1995 to 73.6% in 1999, resulting in a widening U.S.-California gap for this sector.

34 These data provide information about whether employers offer health benefits from the perspective of the employee. Surveys of employers also find lower offer rates in California than nationally among firms of all sizes. See, for example, Kaiser Family Foundation, *Health Care Trends and Indicators in California and the United States: A Chartbook,* Menlo Park, CA: Henry J. Kaiser Family Foundation, June 2000.

EXHIBIT 48. OFFER RATES FOR JOB-BASED HEALTH INSURANCE FOR SELECTED SOCIO-DEMOGRAPHIC GROUPS, EMPLOYEES AGES 19-64, CALIFORNIA AND U.S., 1995 AND 1999

	CALIFORNIA		U.S.		DIFFERENCE BETWEEN CALIFORNIA AND U.S.**	
	1995	1999	1995	1999	1995	1999
OVERALL RATE	78.1%	80.5%	84.2%	85.6%	–6.1*	–5.1*
AGE						
19-24 YEARS	59.7%	68.6%	71.9%	74.5%	–12.2*	–5.9*
25-44 YEARS	79.1%	81.1%	85.4%	86.4%	–6.4*	–5.2*
45-64 YEARS	84.3%	84.8%	87.1%	88.4%	–2.8*	–3.6*
RACE/ETHNIC GROUP						
NON-LATINO WHITE	85.7%	86.6%	86.1%	87.5%	–0.4	–1.0
LATINO	60.3%	65.5%	67.8%	70.5%	–7.4*	–5.0*
ASIAN AMERICAN/PACIFIC ISLANDER	76.7%	83.4%	81.0%	83.3%	–4.3	+0.1
AFRICAN AMERICAN	84.5%	88.4%	84.2%	86.8%	+0.3	+1.6
EDUCATION						
LESS THAN HIGH SCHOOL GRADUATE	48.0%	51.6%	65.4%	66.2%	–17.4*	–14.7*
HIGH SCHOOL GRADUATE	78.6%	82.1%	83.2%	84.8%	–4.7*	–1.7*
COLLEGE GRADUATE PLUS	92.4%	91.9%	93.4%	93.4%	–1.0	–1.5
CITIZENSHIP STATUS						
U.S.-BORN CITIZEN	84.1%	86.4%	85.7%	87.3%	–1.6*	–0.9
NATURALIZED CITIZEN	82.7%	84.4%	83.8%	83.4%	–1.1	+1.0
NONCITIZEN	54.7%	56.7%	62.2%	64.0%	–7.5*	–7.3*

* Difference is statistically significant at $p \leq 0.05$.

** Negative number indicates California is lower than U.S. average; postive number indicates California is higher than U.S. average.

Source: February 1995 and 1999 Current Population Surveys

EXHIBIT 49. OFFER RATES FOR JOB-BASED HEALTH INSURANCE FOR SELECTED EMPLOYMENT GROUPS, EMPLOYEES AGES 19-64, CALIFORNIA AND U.S., 1995 AND 1999

	CALIFORNIA		U.S.		DIFFERENCE BETWEEN CALIFORNIA AND U.S.**	
	1995	1999	1995	1999	1995	1999
HOURLY WAGE						
< $9.51	59.5%	57.6%	74.5%	71.9%	–15.0*	–14.3*
$9.51-$14.25	91.1%	86.5%	89.9%	89.7%	+1.2	–3.2
$14.26-$19.00	89.1%	88.8%	94.0%	92.1%	–4.9*	–3.3
$19.01 +	93.2%	94.5%	92.8%	94.2%	+0.4	+0.3
HOURS WORKED PER WEEK						
0-20 HOURS	65.5%	65.9%	62.4%	65.2%	+3.1	+0.7
21-34 HOURS	58.4%	63.9%	65.9%	72.3%	–7.5*	–8.4*
35-39 HOURS	69.7%	77.5%	83.3%	82.1%	–13.6*	–4.6
40+ HOURS	82.4%	83.9%	88.3%	89.2%	–6.0*	–6.9*
TEMPORARY STATUS						
TEMPORARY	41.4%	51.9%	52.8%	55.5%	–11.4*	–3.6
PERMANENT	79.0%	81.3%	84.9%	86.1%	–5.9*	–4.8*
UNION MEMBERSHIP						
YES	73.3%	91.5%	80.3%	90.7%	–6.9	+0.8
NO	48.4%	59.4%	61.0%	67.8%	–12.6*	–8.4*
SELECTED MAJOR INDUSTRIES						
AGRICULTURE	44.5%	46.0%	49.5%	50.3%	–4.9	–4.2
BUSINESS AND REPAIR SERVICES	61.0%	72.5%	69.2%	76.3%	–8.2*	–3.8
CONSTRUCTION	52.6%	60.6%	61.3%	67.2%	–8.8*	–6.5
MANUFACTURING OF NON-DURABLES	78.5%	73.6%	91.3%	91.8%	–12.8*	–18.2*
PERSONAL SERVICES	60.6%	73.7%	63.7%	63.9%	–3.1	9.9
RETAIL TRADE	65.7%	71.3%	71.8%	75.0%	–6.1*	–3.7

* Difference is statistically significant at $p \leq 0.05$.

** Negative number indicates California is lower than U.S. average; postive number indicates California is higher than U.S. average.

Source: February 1995 and 1999 Current Population Surveys

EXHIBIT 50. ELIGIBILITY RATES FOR JOB-BASED HEALTH INSURANCE FOR SELECTED SOCIO-DEMOGRAPHIC GROUPS, EMPLOYEES AGES 19-64, CALIFORNIA AND U.S., 1995 AND 1999

	CALIFORNIA		U.S.		DIFFERENCE BETWEEN CALIFORNIA AND U.S.**	
	1995	1999	1995	1999	1995	1999
OVERALL RATE	92.3%	90.3%	91.7%	91.9%	+0.6	–1.7*
AGE						
19-24 YEARS	74.9%	70.6%	77.3%	75.0%	–2.4	–4.4
25-44 YEARS	93.8%	92.5%	93.1%	93.5%	+0.8	–0.9
45-64 YEARS	94.5%	93.3%	94.0%	94.7%	+0.5	–1.4
RACE/ETHNIC GROUP						
NON-LATINO WHITE	92.9%	90.3%	91.5%	92.0%	+1.3*	–1.7*
LATINO	90.8%	89.3%	92.4%	90.5%	–1.6	–1.2
ASIAN AMERICAN/PACIFIC ISLANDER	90.1%	91.7%	91.7%	93.0%	–1.6	–1.3
AFRICAN AMERICAN	93.5%	90.0%	92.2%	92.2%	+1.3	–2.2
EDUCATION						
LESS THAN HIGH SCHOOL GRADUATE	92.6%	91.1%	90.4%	90.2%	+2.2	+0.9
HIGH SCHOOL GRADUATE	90.7%	87.6%	90.7%	90.6%	+0.0	–2.4*
COLLEGE GRADUATE PLUS	95.1%	94.7%	94.2%	95.0%	+0.9	–0.3
CITIZENSHIP STATUS						
U.S.-BORN CITIZEN	92.2%	90.0%	91.6%	91.9%	+0.6	–1.9*
NATURALIZED CITIZEN	94.9%	91.1%	93.7%	94.3%	+1.3	–3.2
NONCITIZEN	91.1%	91.2%	91.2%	90.8%	–0.1	+0.4

* Difference is statistically significant at $p \leq 0.05$.

** Negative number indicates California is lower than U.S. average; postive number indicates California is higher than U.S. average.

Source: February 1995 and 1999 Current Population Surveys

Eligibility Rates by Socio-Demographic and Economic Characteristics

Among workers whose employer offers health insurance, we next examine workers' eligibility for those health benefits. California's eligibility rate was similar to the national average in 1995, but it dropped from 92.3% to 90.3% in 1999, while the U.S. rate remained flat (Exhibit 50).

Californians' eligibility declined or remained flat between 1995 and 1999 in almost all groups, except those working 20 hours or less (Exhibits 50 and 51). Despite the large increase in eligibility for these part-time workers, this gain starts from a very low eligibility rate of 31.1% in 1995. In 1999, California's eligibility rates were significantly lower than the nation's for groups that are more economically advantaged — non-Latino whites, high school graduates,

California's eligibility rate is high but declining

EXHIBIT 51. ELIGIBILITY RATES FOR JOB-BASED HEALTH INSURANCE FOR SELECTED EMPLOYMENT GROUPS, EMPLOYEES AGES 19-64, CALIFORNIA AND U.S., 1995 AND 1999

	CALIFORNIA		U.S.		DIFFERENCE BETWEEN CALIFORNIA AND U.S.**	
	1995	1999	1995	1999	1995	1999
HOURLY WAGE						
< $9.51	77.5%	72.2%	82.8%	78.6%	–5.3*	–6.4*
$9.51-$14.25	93.1%	94.7%	94.7%	94.5%	–1.6	+0.2
$14.26-$19.00	95.5%	95.3%	97.2%	96.5%	–1.7	–1.3
$19.01 +	95.7%	89.4%	93.6%	92.9%	+2.1	–3.5
HOURS WORKED PER WEEK						
0-20 HOURS	31.1%	47.5%	44.5%	47.3%	–13.5*	+0.2
21-34 HOURS	74.5%	66.1%	75.6%	71.7%	–1.1	–5.6
35-39 HOURS	87.6%	79.5%	93.1%	89.8%	–5.5	–10.2*
40+ HOURS	97.0%	97.1%	96.7%	97.3%	+0.3	–0.3
TEMPORARY STATUS						
TEMPORARY	44.0%	48.4%	43.6%	45.0%	+0.4	+3.4
PERMANENT	92.9%	91.0%	92.3%	92.5%	+0.6	–1.5*
UNION MEMBERSHIP						
YES	84.6%	86.3%	81.5%	87.4%	+3.2	–1.1
NO	66.9%	65.0%	63.3%	71.0%	+3.7	–6.0
SELECTED MAJOR INDUSTRIES						
AGRICULTURE	88.7%	90.6%	93.3%	89.9%	–4.7	0.7
BUSINESS AND REPAIR SERVICES	94.5%	95.2%	90.9%	93.3%	3.6	1.9
CONSTRUCTION	94.0%	87.2%	91.8%	93.7%	2.1	–6.4*
MANUFACTURING OF NON-DURABLES	96.4%	96.5%	95.6%	96.1%	0.8	0.4
PERSONAL SERVICES	85.3%	87.1%	84.8%	86.5%	0.5	0.6
RETAIL TRADE	85.6%	80.0%	83.5%	82.9%	2.1	–2.9

* Difference is statistically significant at $p \leq 0.05$.

** Negative number indicates California is lower than U.S. average; postive number indicates California is higher than U.S. average.

Source: February 1995 and 1999 Current Population Surveys

U.S.-born workers, those working 35-39 hours per week, and permanent workers — although the statistical significance may reflect the larger sample sizes of these groups. And, despite the economic boom, the construction industries, which had a similar eligibility rate than the United States in 1995, had a lower rate in 1999. Moreover, among low-wage workers, California trailed the national average by 5.3 percentage points in 1995 and by 6.4 percentage points in 1999.

EXHIBIT 52. TAKE-UP RATES FOR JOB-BASED HEALTH INSURANCE FOR SELECTED SOCIO-DEMOGRAPHIC GROUPS, EMPLOYEES AGES 19-64, CALIFORNIA AND U.S., 1995 AND 1999

	CALIFORNIA		U.S.		DIFFERENCE BETWEEN CALIFORNIA AND U.S.**	
	1995	1999	1995	1999	1995	1999
OVERALL RATE	86.6%	87.2%	85.4%	85.0%	+1.3	+2.2*
AGE						
19-24 YEARS	76.2%	81.9%	76.7%	76.3%	–0.6	+5.5*
25-44 YEARS	87.2%	87.1%	85.5%	85.4%	+1.8*	+1.8
45-64 YEARS	88.0%	88.8%	87.7%	86.6%	+0.3	+2.2
RACE/ETHNIC GROUP						
NON-LATINO WHITE	86.8%	87.5%	85.4%	85.0%	+1.4	+2.5*
LATINO	85.3%	85.1%	85.7%	84.4%	–0.4	+0.7
ASIAN AMERICAN/PACIFIC ISLANDER	86.3%	88.5%	86.4%	86.7%	–0.1	+1.8
AFRICAN AMERICAN	88.6%	89.9%	84.8%	85.2%	+3.9	+4.7
EDUCATION						
LESS THAN HIGH SCHOOL GRADUATE	81.7%	79.3%	81.5%	81.7%	+0.2	–2.4
HIGH SCHOOL GRADUATE	84.8%	86.3%	84.0%	83.5%	+0.8	+3.0*
COLLEGE GRADUATE PLUS	91.1%	90.7%	89.1%	88.5%	+2.0	+2.2*
CITIZENSHIP STATUS						
U.S.-BORN CITIZEN	87.3%	87.2%	85.3%	84.9%	+2.0*	+2.3*
NATURALIZED CITIZEN	85.8%	90.4%	87.8%	88.1%	–1.9	+2.3
NONCITIZEN	83.3%	84.6%	85.0%	83.6%	–1.7	+1.0

* Difference is statistically significant at $p \leq 0.05$.

** Negative number indicates California is lower than U.S. average; postive number indicates California is higher than U.S. average.

Source: February 1995 and 1999 Current Population Surveys

Take-up Rates by Socio-demographic and Economic Characteristics

For the employee whose firm offers health insurance and who is eligible for coverage, acceptance or "take-up" of insurance depends on several factors. It depends on the cost of the employee's share of the premium, whether the employee has the option of coverage through a spouse's or parent's plan, and whether an alternative plan that can be privately purchased is cheaper. Employees who have health problems are more likely to consider it essential to take up health benefits, even at costs that most workers might consider unaffordable.

Californians "take up" job-based insurance at a higher rate than Americans as a whole. Exhibit 52 shows that California adult employees in nearly all population groups are more apt to take up job-based insurance than their counterparts in the nation as a whole, and the differences are statistically significant for 19-24 year olds, non-Latino

Californians' take-up rate is higher than the nation's but not for low-wage, low-education workers

EXHIBIT 53. TAKE-UP RATES FOR JOB-BASED HEALTH INSURANCE, FOR SELECTED EMPLOYMENT GROUPS, EMPLOYEES AGES 19-64, CALIFORNIA AND U.S., 1995 AND 1999

	CALIFORNIA		U.S.		DIFFERENCE BETWEEN CALIFORNIA AND U.S.**	
	1995	1999	1995	1999	1995	1999
HOURLY WAGE						
< $9.51	79.7%	73.2%	76.3%	73.1%	+3.4	+0.1
$9.51-$14.25	90.2%	86.8%	88.0%	83.8%	+2.2	+3.0
$14.26-$19.00	87.3%	96.6%	88.8%	89.6%	–1.5	+7.0*
$19.01 +	89.4%	97.4%	90.5%	89.6%	–1.1	+7.8*
HOURS WORKED PER WEEK						
0-20 HOURS	32.7%	71.3%	46.1%	53.2%	–13.4	+18.2*
21-34 HOURS	73.6%	79.5%	59.7%	60.6%	+13.9*	+18.9*
35-39 HOURS	79.1%	67.6%	81.8%	74.8%	–2.7	–7.2
40+ HOURS	89.8%	91.7%	88.3%	87.9%	+1.2*	+4.0*
TEMPORARY STATUS						
TEMPORARY	64.2%	82.8%	57.0%	62.5%	+7.3	+20.3*
PERMANENT	86.8%	87.2%	85.5%	85.1%	+1.2	+2.1*
UNION MEMBERSHIP						
YES	92.0%	87.6%	87.0%	89.9%	+5.1	–2.3
NO	66.9%	80.1%	69.0%	75.3%	–2.0	+4.8
SELECTED MAJOR INDUSTRIES						
AGRICULTURE	77.5%	75.4%	78.3%	76.8%	–0.8	–1.4
BUSINESS AND REPAIR SERVICES	81.1%	83.7%	77.3%	80.3%	3.8	3.4
CONSTRUCTION	86.4%	76.9%	82.6%	83.3%	3.8	–6.4
MANUFACTURING OF NON-DURABLES	86.9%	91.9%	89.7%	90.0%	–2.8	1.9
PERSONAL SERVICES	82.9%	87.1%	77.0%	73.3%	5.9	13.7*
RETAIL TRADE	80.1%	83.4%	73.6%	75.0%	6.5*	8.4*

* Difference is statistically significant at $p \leq 0.05$.

** Negative number indicates California is lower than U.S. average; postive number indicates California is higher than U.S. average.

Source: February 1995 and 1999 Current Population Surveys

whites, those with at least a high school diploma, U.S.-born citizens and part-time workers. Take-up rates are also similar or higher in California than nationally across the selected major industries shown in Exhibit 53, except construction for which the take-up rate is lower in California.

While California's advantage over the U.S. in take-up increased for workers earning more than $14.25 an hour, there was no significant change in the U.S.-California gap for those making $14.25 or less. Similarly, there was no California advantage over the U.S. in take-up rates for California's workers with less than a high school education. Thus, though California's take-up rates are higher than the national average, this is chiefly among the most economically advantaged (Exhibits 52 and 53).

In sum, our findings consistently point to declining coverage of low-wage and low-education workers in California, between 1995 and 1999. Lower take-up rates for these groups, amidst overall high take-up rates for Californians, suggest that rising cost (or falling real wages) is the barrier to purchasing job-based health insurance. While eligibility has fallen and take-up has not significantly increased among California's poorest segment of workers, the greatest gap between California and the United States as a whole persists in offer rates. This 5-6 percentage-point gap over the last four years has been constant, suggesting some systematic factor that allows California's employers to not offer benefits at the same rate as their counterparts nationally. This lower offer rate in California directly contributes to the state's low level of job-based coverage.

FUTURE PROSPECTS FOR JOB-BASED COVERAGE

This part of the report has shown that California has lower job-based health insurance coverage than the country as a whole, but that recent trends show improvement — both with respect to California's relative performance nationally, and for some of the more economically vulnerable population groups in particular. In this section we explore the factors that will determine whether recent encouraging trends are likely to persist in the future.

Between 1998 and 1999, job-based coverage increased considerably in California, with California's gains exceeding those of the United States as a whole. Furthermore, some groups — Latinos, noncitizens, those below the poverty level, single adults with children, and part-time and full-time, part-year workers — have shown some encouraging gains as well.

All of this occurred during a period of strong economic growth coupled with relatively steady health care costs in California. The key question, then, is whether these trends will continue if economic growth subsides, or if health care costs begin to increase more quickly.

It is difficult to predict what will happen to California's economy over the next few years. It is generally agreed, however, that small firms are more likely to offer health insurance coverage to their employees when there is a tight labor market, as there is now. It is therefore not surprising to have seen the recent increase in offer rates among California firms. An economic downturn would almost surely result in another decline in offer rates if firms no longer have to compete as hard for employees.

California's lower offer rates are driving low job-based coverage, compared to the U.S.

Even if good economic times continue, another threat to offer rates is imminent: a resurgence of health care cost inflation. A survey of employers by William M. Mercer Inc. found that in 2001, health care costs for firms and their employees are expected to rise by 17%.[35] This is in sharp contrast to the single-digit increases that have prevailed since 1993. Because of this resurgence in health care cost inflation in the workplace, there is every reason to be concerned that many will drop their coverage and that few that do not now offer health benefits will begin to do so.

Perhaps an even bigger problem, however, is the affordability of premiums by employees. We found that after declining for many years, take-up rates are increasing, at least in California. Previous researchers have found that take-up rates are strongly related to the affordability of the employee share of premiums. In one study that examined changes in job-based coverage between 1987 and 1996, Cooper and Schone found that even though more employers were offering coverage nationally over time, 8% fewer employees were taking up. This was largely because health insurance premiums rose by 90% over the nine-year period, while wages rose only 28%.[36]

If this dynamic occurs again, take-up rates could fall sharply. The Mercer study also found that most employers will be raising employee premiums or cost sharing requirements, often substantially. This is a dramatic change from previous years, when, as a result of tight labor markets, employers were shielding their employees from recent increases in health insurance premiums.[37]

To further analyze this issue, we used published data on the out-of-pocket premium costs paid by California employees from the Kaiser Family Foundation.[38] On average, the annual out-of-pocket premium cost of coverage for California employees was $252 for single coverage and $1,404 for family coverage. Workers pay a larger share of cost for family coverage than for single coverage.[39]

To determine the affordability of such coverage, we calculated the percentage of uninsured working Californians ages 19-64 in various population groups who would have to pay at least 5% of their gross (before-tax) income, and at least 10% of their gross income, to obtain an average-priced employer policy. It should be kept in mind that these are very high expenses for economically vulnerable individuals and families, especially given the fact that we are examining pre-tax income, and do not consider other health care costs besides premiums (for example, the cost sharing for covered services in most health plans and the cost of health services not covered by the plan) or the relative cost of living in California. In particular, we examine the percentage of uninsured single adults without children who would have to pay at least 5% or 10% of income for single coverage, and the percentage of uninsured families (of two or more members) that would have to pay this much of their income for family coverage. (For simplicity, we do not present figures on the cost of single coverage for families.)

35 http://www.wmmercer.com/usa/english/resource/resource_news_topic_121200.htm

36 Cooper PF, and Schone BS, "More Offers, Fewer Takers for Employment-Based Health Insurance: 1987 and 1996," Health Affairs 16(6), November/December 1997: 142-149.

37 http://www.wmmercer.com/usa/english/resource/resource_news_topic_121200.htm

38 Kaiser Family Foundation, Health Care Trends and Indicators in California and the United States: A Chartbook, Menlo Park, CA: Henry J. Kaiser Family Foundation, June 2000.

39 It is noteworthy that employer health insurance premiums are about 10% lower in California than nationally and that employees pay a somewhat lower share of the total premium cost. California workers pay, on average, 11% of the cost for single coverage in California, compared to 16% nationally, and 24% of the cost for family coverage in California, compared to 32% nationally. Kaiser Family Foundation, *Health Care Trends and Indicators in California and the United States: A Chartbook*, Menlo Park, CA: Henry J. Kaiser Family Foundation, June 2000.

A resurgence in health care cost inflation threatens further gains in insurance coverage

The rows labeled "single adult" in Exhibit 54 show the affordability of individual job-based coverage for single individuals. To illustrate how to interpret the table, the first row shows that 27% of working adults ages 19-24 would have to pay at least 5% of their income to enroll in an average-priced employer policy, and that 11% would have to spend 10% or more of their income. A large proportion of employees would be unable to afford the premiums associated with job-based coverage if they could not devote 5% of their gross income to it. This is especially true of those ages 19-24, those below the poverty level, and part-time workers. Among part-time workers, for example, 32% would have to pay at least 5% of their income towards premiums.

The rows labeled "family coverage" in Exhibit 54 show the affordability of job-based coverage for families. Because out-of-pocket premiums are so much higher for family coverage than covering an individual, family coverage constitutes a far greater proportion of income. In the following groups, over 60% of families would have to pay 5% or more of their incomes to purchase coverage: Latinos, young adults, noncitizens, the poor and near poor, part-time workers and full-time workers employed part of the year, and non-high school graduates. Over 20% of Latinos, noncitizens, those below the poverty level, full-time part-year and part-time workers, those who did not graduate from high school, and workers ages 19-29 would have to pay 10% or more of their before-tax income to enroll in family coverage through the workplace.

An obvious question is whether uninsured families can indeed afford to pay 5% or 10% of their income for health insurance coverage. It would appear that most cannot. The California Budget Project has compiled estimates of the cost of living in different California regions for 1998.[40] This includes the estimated cost of housing and utilities, child care, transportation, food, health care, taxes, and miscellaneous expenses. If one subtracts the costs of health care, it was found that an average single parent faces expenses of about $34,000 a year; a two-parent family with one parent working in the labor force would have to spend $27,000 a year, and a two-parent family with both adults working would face expenses of $41,000 a year just to make ends meet. In some urban areas, these costs are much higher. Given that the average family income in the state was only $25,800 that year[41] — and much lower for minorities and those with low educational levels — it is clear that most uninsured Californians could not afford to sacrifice 5% or 10% of this to pay for coverage.

These simulations show that the employee share of health care costs are currently unaffordable for many uninsured employees, and that future increases of the magnitudes that are expected in 2001 are likely to result in a reduction in take-up rates — and a likely resurgence in the state's uninsured rate.

40 California Budget Project, Making Ends Meet: How Much Does it Cost to Raise a Family in California?, October 1999. http://www.cbp.org/reports/9910mem.html.

41 Zuckerman S., "Income in California Fell During 1990s," *San Francisco Chronicle*, August 21, 2000.

Purchasing health insurance is beyond the means of most uninsured families

EXHIBIT 54. PERCENTAGE OF UNINSURED WORKERS WHO WOULD HAVE TO PAY 5% OR 10% OF GROSS INCOME TO ENROLL IN AVERAGE SINGLE-ADULT OR FAMILY COVERAGE EMPLOYER HEALTH PLAN BY SELECTED CHARACTERISTICS AND FAMILY COMPOSITION, AGES 19-64, CALIFORNIA, 1999

	PAY 5% OR MORE OF INCOME	PAY 10% OR MORE OF INCOME		PAY 5% OR MORE OF INCOME	PAY 10% OR MORE OF INCOME
AGE 19-24			**INCOME BELOW POVERTY LEVEL**		
SINGLE ADULT	27%	11%	SINGLE ADULT	60%	23%
FAMILY COVERAGE	79%	37%	FAMILY COVERAGE	100%	72%
AGE 25-29			**INCOME 100-249% OF POVERTY LEVEL**		
SINGLE ADULT	13%	7%	SINGLE ADULT	9%	6%
FAMILY COVERAGE	73%	25%	FAMILY COVERAGE	72%	10%
AGE 30-39			**DID NOT GRADUATE FROM HIGH SCHOOL**		
SINGLE ADULT	13%	4%	SINGLE ADULT	22%	8%
FAMILY COVERAGE	58%	18%	FAMILY COVERAGE	68%	25%
LATINO			**HIGH SCHOOL**		
SINGLE ADULT	19%	7%	SINGLE ADULT	17%	4%
FAMILY COVERAGE	66%	23%	FAMILY COVERAGE	51%	18%
NON-LATINO WHITE			**COLLEGE**		
SINGLE ADULT	15%	7%	SINGLE ADULT	15%	8%
FAMILY COVERAGE	39%	10%	FAMILY COVERAGE	46%	14%
U.S.-BORN CITIZEN			**FULL-TIME FULL-YEAR WORKER**		
SINGLE ADULT	17%	8%	SINGLE ADULT	4%	2%
FAMILY COVERAGE	47%	13%	FAMILY COVERAGE	53%	13%
NATURALIZED CITIZEN			**FULL-TIME PART-YEAR WORKER**		
SINGLE ADULT	6%	1%	SINGLE ADULT	33%	11%
FAMILY COVERAGE	44%	16%	FAMILY COVERAGE	68%	28%
NONCITIZEN			**PART-TIME WORKER**		
SINGLE ADULT	20%	7%	SINGLE ADULT	32%	15%
FAMILY COVERAGE	68%	25%	FAMILY COVERAGE	61%	37%

Note: Average single adult premium used for all respondents who were unmarried and living alone; average two-person family coverage premium used for all respondents who were married, regardless of whether they had children.

Source: March 2000 Current Population Survey

5. PUBLIC POLICIES TO EXPAND COVERAGE FOR CHILDREN AND ADULTS

5

California's 6.8 million uninsured residents deserve the same level of access to health care as the rest of the population. They are overwhelmingly working men and women and their families, playing by society's rules but left out of this basic benefit. As we have seen, these are largely — but not exclusively — moderate- and low-income working families whose employers either do not offer health insurance coverage to anyone who works for them, or who would be required to pay often unaffordable shares of cost for job-based health insurance premiums. They are disproportionately Latino, but whites represent three in 10 of the state's uninsured. U.S.-born citizens account for more than half of California's uninsured residents.

California can improve coverage for its uninsured residents through effective public policies. The state has many policy tools at its disposal. In this final part of the report, we offer a number of recommendations that could help California improve its existing programs and policies and expand them to cover uninsured residents.

THE GOAL IS UNIVERSAL COVERAGE

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 economically developed countries. This goal has wide and deep popular support in the United States.

POLICY RECOMMENDATION

- **Fully fund the study mandated by SB 480 to examine and identify cost-effective ways to extend health insurance coverage to all Californians.**

SB 480, enacted by the Legislature and signed by the Governor in 1999, launched a process to develop a study of alternative approaches to reach universal coverage. The results of this study will help identify cost-effective ways to extend health insurance coverage to all Californians and stimulate political and public dialogue that is necessary to reach this goal. It is important that the state fully fund this important policy analysis.

POLICY RECOMMENDATION

- **Enact a state policy committing California to achieve affordable health care coverage providing good access to quality care that enhances people's health.**

As a first step in the process to reach universal health care coverage, California should declare that it is state policy to extend to all residents universal affordable coverage that provides good access to high quality care that enhances people's health.

Until the United States achieves universal coverage, however, it will be important to find ways to shore up the nation's eclectic arrangements of voluntary employment-based health insurance and public coverage programs.

EXPANDING EMPLOYMENT-RELATED HEALTH INSURANCE COVERAGE

Numerous federal and state reforms have sought to expand private health insurance coverage by removing market barriers facing small firms and by aiding workers who change or lose their jobs to keep their health insurance. Although these reforms have helped some workers, they have not eliminated insurance market practices that make health insurance inaccessible or unaffordable for many individuals (including the self-employed) and for medium-sized businesses. Market reforms that simply guarantee access to the market will not, by themselves, substantially increase the number of people with coverage.[42] The costs of health insurance and the modest financial resources available to most of the uninsured and many employers underscore the necessity of subsidies that can come only from employers and/or government.

Employers currently play a critical role in financing health insurance and making it affordable for their employees — heavily assisted by government subsidies. Employers paid 83% (about $252 billion) of the $303 billion spent nationally on employment-based health insurance in 1998,[43] an amount that would have to be replaced if they do not continue to support employee health benefits. The tax exemption of employer-paid health insurance cost the federal and state governments an estimated $124.8 billion in 1998, with an estimated 68.7% of these tax benefits going to the 36% of the population with family incomes of $50,000 or more.[44] Thus, current health insurance tax policies disproportionately benefit middle- and upper-income workers. Policies and programs that extend these taxpayer subsidy benefits to more employees would enhance the equity of current tax policies in addition to expanding health insurance coverage.

Policy Recommendation

- **To help mid-sized firms offer affordable coverage, firms with up to 200 employees should be included in California's purchasing cooperatives.**

Two purchasing cooperatives — Pacific Health Advantage (more commonly called PacAdvantage, and formerly known as the Health Insurance Plan of California, or HIPC) and California Choice — negotiate with health plans and then offer affordable group health insurance to firms with 2 to 50 employees. The Pacific Business Group on Health (PBGH) Negotiating Alliance enhances the health insurance market clout of large employers (over 2,000 employees), while CalPERS does the same thing for public employers. Mid-sized firms — those with 50 to 200 employees — have no purchasing entity to negotiate favorable rates and benefit packages. Many such mid-sized firms do not provide health insurance to their workers, and would benefit by being eligible for membership in a purchasing cooperative.

42 Sloan FA, Conover CJ, "Effects of State Reforms on Health Insurance Coverage of Adults," *Inquiry*, 1998; 35: 380–293.

43 Sheils J, Hogan P, "Cost of Tax-Exempt Health Benefits in 1998," *Health Affairs*, 1999; 18(2): 176-181.

44 Ibid

Policy Recommendation

- **To encourage more employers to offer health benefits, both the federal government and the state of California could provide financial assistance to low-wage firms that help pay for the costs of health insurance for their employees and spouses and dependent children.**

One of the major impediments to coverage is the inability of many employers to afford this benefit. Among California firms during 1999, the average annual cost of single coverage in an employer-sponsored health plan is $2,052, of which the employer paid an average of $1,800; and the cost of family coverage was $5,496, of which the employer paid, on average, $4,092.[45] This is out of the reach of many employers. Many firms that pay low average wages are likely to offer coverage only if they receive subsidies because the addition of health benefits would represent a large proportional increase in their labor costs.

Tax credits have been proposed to expand health insurance coverage. The use of tax credits is a blunt policy instrument that spreads its benefits to those with coverage more than it generates new coverage.[46] AB 1734, proposed by Assemblymember Helen Thomson in the 1999-2000 legislative session, would have provided tax credits to small employers for health benefits offered to moderate- and low-wage employees. They may be one component of the state's efforts to induce more employers to offer health benefits, but should be targeted to firms with low average wages, which are the ones least likely to afford the costs of providing coverage.

Policy Recommendation

- **To help more workers accept health benefits for which they are eligible, the state of California should provide financial assistance for workers in low-income families to defray part of the costs of purchasing employer-based health insurance coverage.**

Even if firms offer coverage, many employees cannot afford to pay their share of premium costs, and this is particularly true for low-income workers and especially so for family coverage. The average annual employee out-of-pocket contributions for premiums in California in 1999 was $252 for single coverage, and $1,404 for family coverage.[47] As we have seen in Part 4, low-income workers who wish to cover their family through their employer policy will often find these costs unaffordable. AB 1887, proposed by Assemblymember Gilbert Cedillo in the 1999-2000 legislative session, would have offered financial assistance to employees below 250% of poverty if the small firm in which they worked obtained coverage through a purchasing program that would pool contributions from employers, employees, Medi-Cal and Healthy Families, and a new state trust fund. Such a program would be an effective way to help low-income employees take-up their employer's offer of health insurance coverage, as well as helping employers offer affordable health benefits.

45 Kaiser Family Foundation, *Health Care Trends and Indicators in California and the United States: A Chartbook*, Menlo Park, CA: Henry J. Kaiser Family Foundation, June 2000.

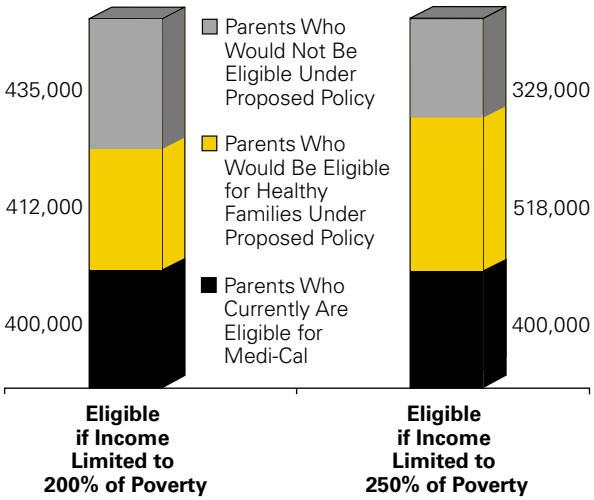
46 Gruber J, Levitt L, "Tax Subsidies For Health Insurance: Costs And Benefits," *Health Affairs*, 2000; 19(1): 72-85.

47 Kaiser Family Foundation, *Health Care Trends and Indicators in California and the United States: A Chartbook*, Menlo Park, CA: Henry J. Kaiser Family Foundation, June 2000.

PUBLIC PROGRAMS TO COVER UNINSURED CALIFORNIANS

The federal government has provided many opportunities for California to draw down federal matching dollars for a number of options to expand coverage for children and for their parents and some other adults. Medi-Cal and Healthy Families, supported by a combination of federal and state funds, are effective vehicles for channeling government subsidies to individuals and families. California has yet to make maximum use of available federal matching funds to provide affordable coverage for families and individuals who need it. It makes enormous policy and fiscal sense to expand coverage through programs in which the federal government picks up half or two-thirds of the cost. The options described below could greatly expand coverage by maximizing use of federal options and funding under Medicaid and CHIP.

EXHIBIT 55. UNINSURED PARENTS BY ELIGIBILITY FOR MEDI-CAL AND HEALTHY FAMILIES UNDER ALTERNATIVE EXPANSION OPTIONS, AGES 19-64, CALIFORNIA



Source: Estimates of eligibility calculated by the UCLA Center for Health Policy Research based on data from the March 2000 Current Population Survey

The Governor's proposed expansion of Healthy Families could benefit up to 412,000 uninsured parents with income eligibility up to 200% of poverty

Policy Recommendation

■ **Expand the Healthy Families Program to parents on the same eligibility basis as for their children.**

Among the 3.1 million uninsured adults who are citizens or legal immigrants, approximately one and a quarter-million are parents of children up to age 18. About 400,000 uninsured parents — one-third of the total — are currently eligible for Medi-Cal (Exhibit 55).

In 2000, the Governor and the Legislature agreed to seek a federal 1115 waiver to extend the Healthy Families Program to uninsured parents whose family incomes or assets exceed the eligibility limit for Medi-Cal. Combined with an effective outreach campaign and a simplified application process, extending Healthy Families eligibility to parents could substantially reduce the number of uninsured adults — depending on the income eligibility policies established for these parents.

The Governor has proposed extending eligibility to those parents with family incomes up to 200% of the poverty level — well below the 250% of poverty allowed for children. However, the proposed expansion would permit deducting allowed expenses from countable income and, for those above Medi-Cal income eligibility levels, waiving any asset test as the state has done for children. Ironically, the lowest income parents, those with incomes at or below 100% of poverty who would qualify for Medi-Cal, must still answer a long set of intimidating questions about assets and provide extensive proof that their possessions have little value — while families with twice the income will have no assets test at all. The Governor's proposal requires parents to pay monthly premiums of $17-$25 a month each for their coverage as well as to meet co-payments similar to those required of state employees.

We estimate that 412,000 uninsured adults (range: 342,000 to 482,000) would be eligible for Healthy Families under the Governor's proposal (Exhibit 55). That would leave about 435,000 uninsured parents who are citizens or legal immigrants but who have no options for subsidized coverage through these programs.

If the Governor raised income eligibility to 250% of poverty — the same as for children — 518,000 uninsured parents (range: 440,000 to 597,000) would be eligible for Healthy Families (Exhibit 55). The additional 106,000 uninsured parents who would be eligible at 250% of poverty but not at 200% of poverty would reduce the number without coverage options to about 329,000.

Expanding parents' coverage to the levels available to their children 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.[48] 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 County Medical Services Program, and support to private hospitals and community clinics.

48 Ku L, and 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.

The expansion of Healthy Families could benefit up to 518,000 uninsured parents if income eligibility is up to 250% of poverty

Policy Recommendation

- **Increase income eligibility for the Healthy Families Program to 300% of the poverty guidelines.**

Beyond increasing enrollment of currently eligible children and increasing parents' eligibility to match that of their children, California could raise income eligibility for both children and parents. If income eligibility were raised from 250% to 300% of poverty (after deductions of allowed expenses), approximately 62,000 more uninsured children (range: 36,000 to 88,000) and about 57,000 more uninsured parents (range: 33,000 to 82,000) would be added to eligibility. So raising income eligibility to 300% of poverty could extend the benefits of these programs to more of the state's uninsured children and their parents.

ENHANCING ENROLLMENT OF ELIGIBLE PERSONS IN MEDI-CAL AND HEALTHY FAMILIES

The number of uninsured children and adults who are eligible for Medi-Cal or Healthy Families suggests that efforts to enroll eligible residents in these programs, and retain them once they are enrolled, ought to be enhanced. Although the state has improved its outreach and enrollment efforts, these efforts could be made more effective by some policy changes.

Policy Recommendation

- **The state should more fully engage community-based organizations, churches and schools in culturally sensitive outreach and expand funding for these efforts. Outreach should emphasize locally targeted media, use expanded federal authority and funds to enroll children and adults in community settings away from the welfare office, and mobilize community leaders in these efforts.**

Despite apparent progress, Medi-Cal and Healthy Families can do more to enroll the 1.3 million uninsured eligible children and adults. First, outreach efforts to inform parents and enroll eligible children could more fully engage community-based organizations, schools, and churches. On January 7, 2001, the President announced new federal rules intended to make it easier for states to conduct outreach to and enroll children at convenient places, such as child care centers and school nurses' offices. Community groups and schools have proved very successful in reaching and enrolling eligible children when they have the resources to mount sustained efforts. In the past, California's outreach has relied too heavily on expensive media campaigns and not effectively engaged these other channels of communication. The state has begun to involve these groups, but it has not yet taken full advantage of their willingness and their effectiveness nor has it mobilized community leaders on behalf of this effort.

About two-thirds of uninsured children eligible for Medi-Cal or Healthy Families are Latino, which is expected given the high uninsured rate among Latino children. Outreach efforts could be more targeted and culturally sensitive if they were informed by reasonably precise estimates for local areas and for ethnic groups, but these data currently are lacking — a gap that will be ameliorated when the California Health Interview Survey (CHIS) data are available toward the end of 2001.[49]

Other changes could further simplify and speed the application process if the Governor and the Legislature use existing authority creatively.

Policy Recommendation

- **Fully implement Express Lane Eligibility to expedite enrollment in health programs for children who are participating in Food Stamps, the School Lunch Program, and WIC.**

"Express Lane Eligibility" is a way to expedite enrollment into 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, the National School Lunch Program, and the Supplemental Nutrition Program for Women, Infants and Children (WIC). 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 duplicative red tape. Governor Davis has approved funds to plan for Express Lane Eligibility, and the Department of Health and Human Services is expected to report options to the Legislature early in 2001.[50]

Policy Recommendation

- **Simplify the application and eligibility process for Medi-Cal and the Healthy Families Program by replacing income documentation with a "paperless" system used by many other states.**

In addition to improving outreach and coordination with other means-tested programs, the enrollment application form and process can be made much easier and more applicant-friendly. Although much shorter than the original 28-page Healthy Families and Medi-Cal application booklet for children, the application form itself could be further shortened and the process made simpler — changes that are well within the current statutory and regulatory authority of the state. One simplification the state could make that would significantly facilitate the application process would be to replace income documentation with a signed declaration. This paperless system still permits the state to verify applicants' income through administrative records already available electronically and with monitoring and audits after eligibility has been determined. Federal law allows this easier paperless system, which 12 other states have adopted for their Medicaid or separate CHIP programs or both — including states as different from each other as Alabama, Washington, Vermont, Florida and Michigan.[51]

49 For information about the California Health Interview Survey (CHIS), visit the Website at: www.CHIS.ucla.edu.

50 *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.

51 Cohen-Ross D, and Cox L, *Making It Simple: Medicaid for Children and CHIP Income Eligibility Guidelines and Enrollment Procedures — Findings from a 50-State Survey,* Washington, D.C.: Kaiser Commission on Medicaid and the Uninsured, October 2000.

Policy Recommendation

- **Further simplify the application and eligibility process for Medi-Cal and the Healthy Families Program for children and adults by replacing the allowed expense deductions with an expanded income disregard as allowed under federal law.**

The current method of calculating countable income allows applicants to deduct expenses for work and childcare from their countable income. This allows more children to qualify, but itemizing each expense, submitting receipts or other proof, and deducting the value of each expense from income on a case-by-case basis can be extremely complex. This procedure discourages some families from applying, and it adds administrative cost to determining eligibility.

These itemized deductions from income could be greatly simplified. The state could replace the current complex method with a standard income deduction, also called an "income disregard," so that neither families nor eligibility workers would have to spend time collecting documentation of expenses or doing the math. The standard income deduction is similar in concept to the one allowed by the Internal Revenue Service in calculating taxes; federal law permits this in both Medi-Cal and Healthy Families.

A standard income deduction would eliminate a major barrier to enrollment for eligible children (and parents) by simplifying the process. If this standard deduction were adopted and disregarded income up to 300% of poverty, only about 48,000 uninsured children (range: 25,000 to 71,000) and 48,000 uninsured parents (range: 26,000 to 71,000) would be eligible above the current approach of setting the income eligibility at 250% of poverty and then allowing specified deductions. However, it is likely that a larger proportion of all eligible uninsured children and parents would actually enroll than is the case with current income deductions because this administrative barrier would be lifted.

Policy Recommendation

- **Reduce fragmentation for families by (1) integrating Medi-Cal and Healthy Families into a new program, or (2) creating an administrative overlay that retains separate program eligibility and funding but makes the programs seamless for enrollees, or (3) establishing a "bright line" between the programs so that all children and adults in a family are in the same coverage program.**

Another barrier is raised by the fragmentation inherent in dividing beneficiaries between two separate programs, Medi-Cal and Healthy Families, that differ in eligibility by age and income. These programs benefit millions of Californians, but their patchwork character fragments coverage for families and individuals who must navigate multiple programs. Families may weave in and out of either program as income fluctuates and as children grow older. They may also have children spread between the two programs because of different income eligibility levels for different ages of the child. This patchwork system increases administrative costs for multiple bureaucracies needed to administer differing programs, rules, and application and eligibility determination processes. It also is a frustrating experience for families and individuals who must deal with so many bureaucracies.

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 all would be enrolled in Medi-Cal and those above that level would be enrolled in Healthy Families.[52] Equally important would be to make eligibility policies for parents in Medi-Cal the same as the policies that have been proposed by the Governor for parents in Healthy Families, which are the same as current policies for their children in Medi-Cal and in Healthy Families.

Fragmentation could be even more fully remedied by integrating Medi-Cal and Healthy Families into a consolidated program, which could be called the "Healthy Californians Program" or simply adopt the existing name of the Healthy Families 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.[53]

Policy Recommendation

- **To avoid dumping eligible children out of Medi-Cal, vigorously implement the 12-month continuous eligibility for children, the elimination of the quarterly status report, and new procedures for retaining Medi-Cal for eligible persons when welfare ends.**

Some changes adopted in 2000 have the potential to greatly improve retention of children in Medi-Cal. Starting January 1, 2001, children in Medi-Cal will have 12 months of "continuous eligibility," the same as in the Healthy Families program. In addition, quarterly status reports have been dropped; this could avoid dumping thousands of eligible families from Medi-Cal simply because they did not complete and send in complicated eligibility verification forms every three months. Other changes, scheduled to take effect July 1, 2001, would prevent children and parents from improperly losing Medi-Cal when welfare ends. If implemented properly, these three reforms could result in protecting California's lowest income children and parents from uninsurance throughout the year.

Policy Recommendation

- **Take the eligibility determination process for California's public health care programs out of the welfare system.**

Medi-Cal has been burdened by another barrier for many families: its stigma as "welfare medicine." From its origins as a public assistance program, Medicaid seemed to operate on a guiding philosophy of "Keep out ineligible children." This attitude generated elaborate application procedures and stigmatizing means tests in welfare offices that discouraged

52 According to the National Governors Association, 29 states currently 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. http://www.nga.org/Pubs/IssueBriefs/2000/000120MCHUpdate.asp#1 (Jan. 11, 2001).

53 AB 1887, sponsored by Assemblymember Gil Cedillo in the 2000 legislative session, would have created such an administrative overlay.

many parents from enrolling their eligible children.[54] Given that both California and the federal government have adopted a policy goal of covering all eligible children, California could eliminate these stigmatizing administrative policies that erect barriers to achieving that goal. Replacing intrusive and unnecessary requirements to document income and assess assets would help reduce stigma. But completing this de-stigmatization would require transferring the responsibility for Medi-Cal eligibility determination from local welfare agencies to the state Department of Health Services, which already has overall administrative responsibility for Medi-Cal. Avoiding this unnecessary review by welfare agencies would also save tens of millions of dollars in administrative costs for eligibility determination that could help offset the costs of expanded coverage.[55]

3.7 MILLION ADULTS HAVE NO CURRENT OR PLANNED COVERAGE OPTIONS

Even under the higher income limit for parents, about 3.7 million uninsured adults would not qualify for Medi-Cal or the proposed expansion of Healthy Families. About seven in every 10 of these uninsured adults — a total of 2.6 million persons — are citizens or legal immigrants.

Two-thirds of these uninsured citizens and legal immigrants are single adults; very few state or federal programs assist them with their medical expenses. Despite the absence of subsidy programs, more than 400,000 of these uninsured adults have family incomes below poverty — that is, less than $8,667 for a single adult or $11,214 for a married couple. Another 750,000 are near poor, with family incomes between 100% and 249% of poverty — less than $21,668 for a single adult or $28,103 for a couple. At these income levels, it is unlikely that adults would find health insurance coverage affordable without substantial contributions from employer and/or government.

Policy Recommendation

- **Apply for a section 1115 waiver to restructure the Medi-Cal and Healthy Families Programs to open them to people who do not meet traditional categorical requirements.**

In addition to expanding the Healthy Families Program to the parents of eligible children, California could restructure both its Medi-Cal and Healthy Families programs and open them also to people who do not meet traditional requirements. These requirements formerly restricted enrollees to people in a family with dependent children, disabled nonelderly adults, and adults age 65 and over. With a federal section 1115 waiver, the state could enable uninsured families or individuals who meet Medicaid or CHIP eligibility criteria under current programs to enroll at no cost or low cost to them, and allow those who do not qualify for current programs to buy into them by paying an income-adjusted premium with the state picking up the costs of their subsidies. As of 2000, 15 states had used either section 1931 or an 1115 waiver to cover parents to at least 100 percent of the poverty level. At least four states enable families above the Medicaid or CHIP income eligibility levels to buy into the program.[56]

54 Perry, Michael J., Evan Stark, R. Burciaga Valdez, *Barriers to Medi-Cal Enrollment and Ideas for Improving Enrollment: Findings from Eight Focus Groups in California with Parents of Potentially Eligible Children*. Menlo Park, CA: Henry J. Kaiser Family Foundation; 1998.

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

56 Krebs-Carter M, and Holahan J, *State Strategies for Covering Uninsured Adults*, Discussion Paper, Washington, D.C.: The Urban Institute, February 2000. The waiver option is found in section 1115 of the Social Security Act.

Policy Recommendation

- **The state of California should increase subsidies to MRMIP to expand opportunities for low-income persons who have been denied coverage in the private health insurance market.**

Although the source of most private health insurance is the employment market, there is also a market for individually purchased coverage. About 5% of Californians ages 19-64 had such coverage in 1999. California already has an innovative public program, the Major Risk Medical Insurance Program (MRMIP), that helps subsidize individual coverage, aimed at those who have been turned down for coverage by a private insurer. Since 1991, about 72,000 Californians, mainly women ages 40-59, have received coverage through MRMIP.[57] Despite a hefty state subsidy for the program, MRMIP enrollees pay 125% to 137.5% of what an average risk person would pay — a sign of their desperation to obtain coverage. Nevertheless, MRMIP has a waiting list of over 5,000 people.[58] Most Californians who could benefit from individual coverage, however, have not been turned down for coverage previously; rather, they cannot afford the premiums.

Policy Recommendation

- **Local jurisdictions can mobilize community leadership, encourage or require contractors to offer health benefits to their employees, and generate local resources to expand coverage of their residents.**

Some counties and cities have stepped up to the plate to help their residents obtain coverage. The City of San Jose and Santa Clara County both have funded programs to help enroll eligible children in Medi-Cal and Healthy Families and to extend coverage to many children who do not meet the requirements for these programs. Alameda County has started a program to cover adults and children who are not eligible for Medi-Cal or Healthy Families, funded by foundation grants, savings from the county-sponsored Medi-Cal managed care plan, and tobacco lawsuit settlement funds. San Francisco, Santa Clara, and Alameda Counties are covering home care workers in county-sponsored community health plans with matching funds from federal, state, and local governments. Los Angeles City's "living wage" ordinance is designed to encourage employers affected by it (those who contract with the city, lease city land, or receive substantial city subsidies) to offer health benefits to their employees. Los Angeles County, San Francisco, San Jose, and some other cities and counties have passed similar policies and ordinances, affecting a total of as many as 40,000 families in California.[59]

57 Managed Risk Medical Insurance Board Web site: http://www.mrmib.ca/gov.

58 Personal communication from Sandra Shewry, Executive Director, Managed Risk Medical Insurance Board, November 16, 2000.

59 Personal communications from Lucien Wulsin, Jr., J.D., Director, Insure the Uninsured Project, and from Madeline Janis-Aparicio, JD, Executive Director, Los Angeles Alliance for a New Economy, January 16, 2001.

Some counties are taking a broad community-based approach to expand coverage to uninsured residents. In San Diego, for example, a broad coalition of county, business, labor, and health groups formed to promote enrollment of eligible children in Medi-Cal and Healthy Families, and to work on a request for a federal waiver that would enable San Diego to provide eligibility in these programs to additional groups of people. The coalition also is planning business resource centers to encourage employers to use available public and private resources to offer coverage. In addition, San Diego-based Sharp Health Plan now provides a partial subsidy, funded by foundation grants, to small low-wage firms that have not offered coverage before.[60]

More local jurisdictions can combine local leadership, policy initiatives, and some locally generated resources to expand coverage of their residents. These local efforts, like those noted above, can encourage community leaders to energize campaigns to enroll eligible children and adults in Medi-Cal and Healthy Families, develop local policies and programs that add to available coverage options, and mobilize community energy behind these efforts. Orange County voters, for example, enacted an initiative overriding the county board of supervisors to devote all their tobacco lawsuit settlement funds to improving health care access. As important as these local programs and campaigns are, however, they cannot substitute for expanded state and federal resources and policies to cover the uninsured and, ultimately, to achieve universal coverage.

Policy Recommendation

- **Health care "safety net" providers will continue to need federal, state and local financial support to meet the needs of those who remain uninsured.**

Low- and moderate-income uninsured adults who are under age 65, do not have dependent children and who are not disabled currently must rely on the health care safety net — county hospitals and clinics, community-based clinics and health centers, and private hospital emergency rooms. These safety-net, or "open door," services meet critically important community needs for care rendered on a sliding fee scale, based on ability to pay. Public hospitals and some private hospitals also meet broader community health care needs, from trauma care to training doctors and nurses.[61]

Even if most of the recommendations in this report were adopted and effectively implemented, it is likely that many California residents would remain uninsured. The 1.1 million uninsured adults who are undocumented immigrants are unlikely to be entitled to more than emergency services under Medi-Cal. Those whose employers do not offer health benefits and those who cannot afford the premium share required for job-based insurance will continue to depend on the health care safety net. County-run hospitals and clinics, and community-based urban, rural and migrant clinics — a substantial portion of the health care safety net —provide care to many undocumented immigrants who have few, if any, other options. Many safety-net providers also meet the needs of patients with Medi-Cal or Healthy Families coverage,

60 Personal communication from Nick Macchione, MPH, Deputy Director, San Diego County Health and Human Services Agency, January 17, 2001.

61 See Bindman AB, Grumbach K, Bernheim S, et al., "Medicaid Managed Care's Impact On Safety-Net Clinics In California," *Health Affairs* 2000; 19(2): 194-202; Grogan CM, Gusmano MK, "How Are Safety-Net Providers Faring Under Medicaid Managed Care?," *Health Affairs* 1999; 18(2): 233-237; and Norton SA, Lipson DJ, Public Policy, Market Forces, and the Viability of Safety Net Providers Washington, DC: Urban Institute, September 1998. For the safety net perspective, see *California's Uninsured and the Future of Open Door Providers*, California Association of Public Hospitals and Health Systems, Berkeley, CA: April 1999.

especially those who desire culturally competent services. These providers will continue to need federal, state and local financial support to meet these needs.

CONCLUSION

California's 6.8 million uninsured residents face tremendous barriers to obtaining needed care. California's uninsured children and adults receive fewer preventive services that help reduce the risk of disease and detect diseases at an earlier stage. They receive less care for chronic conditions (such as asthma, diabetes, and high blood pressure) that can help reduce disability and increase productive years of life. And 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.

The state's strong economic growth has enabled more families and individuals to obtain job-based insurance, resulting in a lower uninsured rate for the first time in several years. But the future prospects for this trend continuing seem uncertain at best. The economy appears to be cooling, accelerated in California by the energy crisis — a trend that may be undermining the major factor in the state's recently expanding coverage. And there is clear evidence that health insurance premiums are going to rise by double digits in 2001, making health insurance coverage less affordable at the very time when the labor market is likely to slacken. When the economy does contract and health insurance costs rise, more Californians will almost certainly become uninsured.

California has the opportunity and the resources to address this problem now. Federal policy offers the state numerous opportunities to expand coverage in Medi-Cal and Healthy Families — with federal matching funds picking up half to two-thirds of the cost. In addition to altering policies and procedures in order to more effectively enroll currently eligible children and adults, the state can expand Medi-Cal and Healthy Families to include more of its uninsured residents. California certainly should maximize its options to cover parents of eligible children, for whom the state can receive 2-to-1 matching funds under a CHIP (Healthy Families) waiver. But it also has other options to enroll other adults in these programs and to encourage employers to offer and help pay for coverage for their employees and their employees' families and to help make employment-based health insurance affordable to low-wage workers.

In the longer run, California and the nation need to extend to all residents affordable coverage that provides good access to high quality care that enhances people's health. 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. Some other states have gotten closer to the goal of universal coverage than has California — Rhode Island, Minnesota, Iowa, Missouri, Wisconsin, Massachusetts, Pennsylvania, Michigan, Tennessee, and New Jersey, to name just a few. These states are very diverse in their populations, economies, and politics. But California has economic and fiscal resources, the availability of matching federal funds, unmatched technical assets, and a politically active population. Together with effective political leadership, California could continue to expand health insurance coverage and ultimately achieve universal coverage.

APPENDIX. NOTES ON DATA AND METHODS

appendix

DATA SOURCE

This study relies on analyses of the Current Population Survey (CPS) for its estimates of health insurance coverage. Like many other research agencies, the UCLA Center for Health Policy Research uses the CPS, as well as other data sources, to estimate the number and percent of the population with different sources of health care coverage and those who are uninsured. Most of our estimates are drawn from the March 1995-2000 CPS. Those on offer, eligibility, and take-up rates of job-based insurance among employees are based on the February 1995, 1997, and 1999 CPS.

The March CPS asks respondents about health insurance coverage for each family member during the previous calendar year. Individuals insured by any source at any time during 1999 were counted as insured. Because a person may have multiple sources of coverage reported for 1999, a single hierarchical variable was created to reflect rank ordering of reported health insurance coverage. We counted persons who reported having coverage through their own or a family member's employment at any time during 1999 as covered by job-based health insurance. Those who reported having private health insurance but no job-based coverage were classified as having "privately purchased health insurance." Those who did not have any private coverage, but who had Medicaid coverage at any time during the year were counted as having coverage through that federal-state program. We include coverage in the Healthy Families Program with Medicaid because it is not broken out clearly in the CPS data and because the number of persons covered by that program would be a very small portion of the sample, resulting in a very unstable estimate. Persons who had none of the above sources of coverage but did report coverage through another public program were counted as "other public." Those with no reported coverage of any kind during the year were categorized as "uninsured."

INCOME ELIGIBILITY FOR MEDI-CAL

We used data from the March Current Population Survey to make our estimates of income eligibility for Medi-Cal. We used CPS data to construct variables that reproduce, as closely as feasible with these data, the eligibility requirements for Medi-Cal and Healthy Families under the various policies. We took account of age, family structure, pregnancy status, family income, "program linkage" (disability, hours worked per month, marital status), an estimated value of family assets, and immigration and citizenship status. For more detail on the methods we used, see Kincheloe J, Brown ER, and Yu H, *Simplifying and Expanding Health Insurance Programs for Low-Income Working Parents and Their Children*, Los Angeles: UCLA Center for Health Policy Research, May 2000.

DATA LIMITATIONS

Estimating Medi-Cal Coverage

It is widely accepted that the CPS, a population-based survey, underestimates the number of persons covered by Medicaid compared to administrative data provided by the states to the federal Health Care Financing Administration. The California Department of Health Services' administrative data on Medi-Cal enrollment are about 10 percent higher than estimates derived from CPS data for comparable periods of time. A recent study by the Center assessed differences between the CPS and Department of

EXHIBIT A1. COMPARISON OF CALIFORNIA DEPARTMENT OF HEALTH SERVICES AND CURRENT POPULATION SURVEY ESTIMATES OF MEDI-CAL COVERAGE BY AGE GROUP, 1995

	DHS ESTIMATE	CPS ESTIMATE	CPS AS % OF DHS
AGE GROUP			
0-17	2,970,504	2,697,471	90.8%
0 TO 5	1,393,618	1,206,943	86.6%
TO 17	1,576,885	1,490,528	94.5%
18-64	2,076,783	1,889,068	91.0%
18 TO 20	245,023	235,372	96.1%
1 TO 64	1,831,760	1,653,696	90.3%
65+	567,823	439,643	77.4%
UNKNOWN	**2,489**		0.0%
TOTAL	**5,617,599**	**5,026,182**	**89.5%**

Source: March 1996 Current Population Survey and unduplicated count of Medi-Cal beneficiaries in October-December 1995 provided by California Department of Health Services. Excerpted from 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.

Health Services estimates of Medi-Cal enrollment in California.[62] Using March 1996 CPS data, the Center estimated that 5,026,000 Californians were covered by Medi-Cal in 1995, compared to 5,617,599 beneficiaries reported by the Medi-Cal program for October-December 1995, which was judged to be an appropriate comparable time period. As Exhibit A1 demonstrates, the reporting differences were greater for young children and the elderly than for older children or nonelderly adults. Similar limitations may also apply to estimates of Healthy Families enrollment.

The differences between administrative data and population-based survey estimates of Medi-Cal enrollments are due to a number of factors, all of which are discussed in detail in the published report. One difference may be due to the way DHS and CPS specify their populations. Medi-Cal data typically include both the institutionalized and noninstitutionalized populations while the CPS samples only the noninstitutionalized population. In the report from which the above data were drawn, the authors eliminated institutionalized beneficiaries from the Medi-Cal count. In addition, Medi-Cal data include homeless beneficiaries while the CPS samples only persons living in residences. The authors could not compensate for this disparity. Another potential source of differences may be due to errors in the sampling frame of the CPS. If the CPS total population sampling frame does not accurately reflect the population of California, then any estimates derived from the CPS could result in underreporting of estimates. The authors compared CPS population estimates with those from the

62 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.

Department of Finance to measure this variation. Another measurement issue that may account for some of the CPS-Medi-Cal differences is that the CPS and the DHS Medi-Cal administrative data totals may not cover the same period of time. The authors adjusted for this difference by using the unduplicated count of Medi-Cal beneficiaries for the period October–December, which they judged most closely matched the period for which many CPS respondents actually reported.

Finally, we believe that some respondents may not realize they have Medi-Cal coverage and may misreport it. Some persons enrolled in private managed care plans paid for by Medi-Cal may report their coverage by the private plan name rather than acknowledging Medi-Cal as the source of payment for that coverage. This tendency would under-report Medi-Cal coverage and over-report private health insurance. Among the elderly, some low-income persons may not realize that Medi-Cal is supplementing their Medicare coverage, resulting in under-reporting of Medi-Cal coverage.

Estimating Medi-Cal Eligibility.
The estimates produced by this study may underestimate eligibility for Medi-Cal — that is, the number of persons who are not currently covered by Medi-Cal but who are already eligible. Although the study counts all persons who report being enrolled in Medi-Cal in estimates of Medi-Cal eligibility and enrollment, the report may underestimate eligibility for the following groups due to data limitations:

The Medically Needy. This study does not capture parents who qualify under the Medically Needy Families program with a share-of-cost, but who are not enrolled. We termined current Medi-Cal eligibility using income limits for no-share-of-cost Medi-Cal. In one sense, there are no income limits for the Medically Needy program. Instead, families with incomes that exceed a certain amount must incur a share-of-cost each month before Medi-Cal will pay for services received. This means that many more persons are eligible for Medi-Cal with a share-of-cost, as long as they meet other program criteria. These criteria include being in a household with children and passing the asset test.

Transitional Medi-Cal. Families who become ineligible for welfare because their earnings increase beyond the Section 1931(b) limits are eligible for transitional Medi-Cal. They are eligible for Medi-Cal with no income limit for the first six months, and a limit of 185 percent of poverty for an additional 18 months. Families who qualify for transitional Medi-Cal, but are not enrolled, are not captured in this study as eligible.

Section 1931(b) "Applicants" vs. "Recipients." There are differences in the eligibility requirements for individuals who are applying for Medi-Cal (applicants) and for those who are continuing on Medi-Cal (recipients). Recipients are allowed to have higher incomes. Individuals are considered recipients for four months after they go off Medi-Cal. Among persons who were not already enrolled in Medi-Cal, we were able to identify those who would qualify as applicants but, due to data limitations, not able to identify eligible individuals who would qualify as recipients. As a result of this limitation, estimates of persons currently eligible for Medi-Cal would be higher if we were able to identify those persons who were uninsured but had been covered by Medi-Cal within the last four months.

Child Support or Alimony Paid. The CPS asks about child support or alimony received by a family, but it does not ask about any family expenses paid, including those for child support or alimony. Therefore, in considering eligibility, child support and alimony *paid* were not deducted from family income as they would be in an actual eligibility determination process. As a result, our estimates of current eligibility do not capture individuals who are not enrolled in Medi-Cal, and who meet income eligibility only when child support and alimony they paid out are deducted from their family income. The absence of information about child support payments should not greatly affect the estimates because child support enforcement rates are low in California — only 39.7 percent of child support cases pay any money at all toward child support (State Office of Child Support).

FAMILY INCOME RELATIVE TO FEDERAL POVERTY LEVEL AND GUIDELINES

In most of the report, we measure poverty using the "federal poverty level" (or poverty thresholds), developed by the Social Security Administration and updated annually by the Census Bureau. The poverty thresholds are used for statistical purposes: to determine, for example, the number of persons living below poverty. A person's level in the poverty depends on total family income and the number of persons in the family. In 1999, the poverty level was $8,667 for one person under age 65, $11,214 for a family of two under age 65, $13,290 for a family of three, and $17,029 for a family of four, etc. (The poverty thresholds are available from the Census Bureau at http://www.census.gov/hhes/poverty/threshld/thresh99.html.)

We use the Federal Poverty Guidelines, published by the U.S. Department of Health and Human Services (DHHS), to estimate eligibility for Medi-Cal and Healthy Families. The guidelines 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 for poverty level, but the poverty guidelines count incomes of the immediate ("nuclear") family members, excluding incomes of other household members. In 1999, the poverty guidelines were $8,240 for a family of one, $11,060 for a family of two, $13,880 for a family of three, and $16,700 for a family of four, etc. (The poverty guidelines are available from DHHS at http://aspe.hhs.gov/poverty/99poverty.htm.)

UNDOCUMENTED IMMIGRANT STATUS

The Current Population Survey and most other surveys of the general population do not directly ask noncitizens whether they are legal or undocumented residents. Nevertheless, we were able to model undocumented status based on information from a household survey of Mexican immigrants in Los Angeles (see Marcelli EA, Heer DM, "The Unauthorized Mexican Immigrant Population and Welfare in Los Angeles County: A Comparative Statistics Analysis," *Sociological Perspectives* 1998; 41: 279-303). First, using CPS data, we classified respondents into: (1) noncitizens; (2) naturalized citizens; or (3) U.S.-born citizens. Second, we modeled undocumented status with the Marcelli and Heer data. Third, based on that model, we classified each CPS respondent who was identified as a noncitizen as either a "legal immigrant" or "undocumented." Although this method of imputing undocumented status has some disadvantages, given data limitations, we consider this method and these data the best available for this purpose.

THE STATE OF HEALTH INSURANCE IN CALIFORNIA: RECENT TRENDS, FUTURE PROSPECTS

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