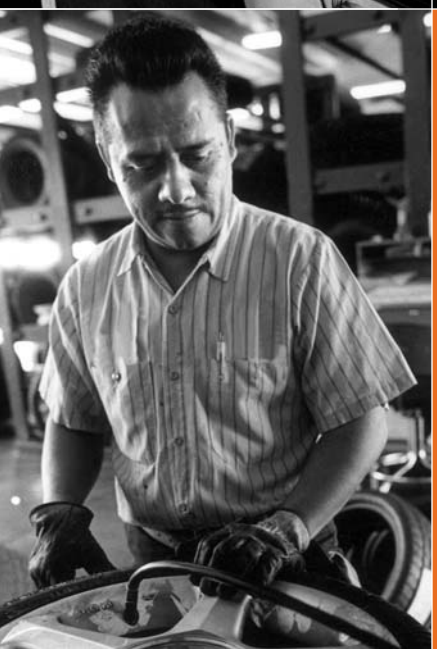
The State of Health Insurance in California

Findings from the 2003 California Health Interview Survey









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August 2005

UCLA CENTER FOR HEALTH POLICY RESEARCH

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The California Endowment
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IN CALIFORNIA:

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summary

More than one in five nonelderly Californians lacked some form of health insurance coverage for all or part of the year in 2003—nearly 6.6 million children and adults under age 65, which is more people than the entire population of the state of Massachussetts. More than 3.7 million of these Californians lacked health insurance coverage for at least the entire year.

During this period, employment-based health insurance fell both nationally and in California. However, while the rate of uninsurance rose nationally, California's overall uninsured rate remained constant. In California, public health care coverage programs grew significantly, particularly in Medi-Cal and Healthy Families, offsetting the decline in employer-sponsored coverage. Privately purchased insurance also grew, although less than Medi-Cal and Healthy Families.

This report, based on data from the 2003 and 2001 California Health Interview Surveys (CHIS), examines health insurance coverage, and the sources and consequences of periods of uninsurance for the nonelderly population in California. Using the most recent data available, this report:

1) Paints an overall picture of health insurance and uninsurance in California and the changes experienced between 2001 and 2003;
2) Examines changes in employer-based insurance in detail;
3) Profiles Medi-Cal and Healthy Families enrollees and their families, as well as children who are uninsured but eligible for coverage in these programs;
4) Examines the consequences of being uninsured versus having coverage as it relates to access to care and getting necessary care; and
5) Discusses the advantages and disadvantages of key public policy options to extend coverage to California's 6.6 million uninsured residents.

AN OVERVIEW OF HEALTH INSURANCE COVERAGE IN CALIFORNIA

The nonelderly population relies heavily on employment for health insurance coverage, but just a little over half had employment-based coverage throughout the year. Between 2001 and 2003, all-year employment-based health coverage fell 2.1 percentage points for adults and 3.9 percentage points for children. Every age group, every income group, and every racial and ethnic group lost employer-based coverage between 2001 and 2003.

In spite of this decline in employment-based coverage, the rate of uninsurance—that is, the proportion of the nonelderly population that has no private or public coverage—remained unchanged in California during this period. Coverage through public programs and privately purchased health insurance offset the losses from job-based insurance. Children's coverage through Medi-Cal and Healthy Families jumped 5.1 percentage points, resulting in a *decrease* in children's rate of uninsurance. Adults' privately purchased and Medi-Cal coverage rose sufficiently to offset most of their losses in job-based coverage, leaving their uninsured rate statistically unchanged. Nevertheless, more than one in five nonelderly Californians still experienced a lack of coverage for all or part of 2003.

Among very-low-income Californians, employment-based coverage plummeted. The decline in job-based coverage between 2001 and 2003 hit all income groups, but more

among lower-income Californians than those with higher incomes. While the uninsured rate for adults living in poverty increased between 2001 and 2003, the uninsured rate for children below the poverty line *dropped* a stunning 6.9 percentage points—a result of children's far more generous eligibility for and high rate of enrollment in Medi-Cal and Healthy Families.

Nearly two-thirds of persons who were uninsured for all or part of the year had family incomes below 200% of the federal poverty level (FPL)—for example, less than $30,000 a year for a family of three in 2003. However, 14.4% had family incomes at 400% FPL or greater.

Disparities in health insurance coverage are also seen across racial/ethnic groups. Nonelderly Latinos and American Indian/Alaska Natives report the highest rates of uninsurance and the lowest rates of employer-based coverage compared to other racial/ethnic groups. Medi-Cal and Healthy Families provided coverage to approximately one-quarter of Latinos, African Americans, and American Indian/Alaska Natives. Whites consistently had the lowest rates of uninsurance and the highest rates of employer-based coverage.

The vast majority of the uninsured are working adults and their families, a direct result of the lack of alternative affordable coverage opportunities when employer-based coverage is not available. In 2003, three-quarters of the uninsured were workers and their families, including 60% who were full-time employees or in families with at least one full-time employee.

The main reason that uninsured persons give for not having coverage is "I can't afford it" (43%), with little variation by family work status. However, among those in self-employed families, six in 10 said insurance was unaffordable. Less than one in 10 say they don't have health insurance, either because they are healthy and don't need it or because they don't believe in it. Only two out of 100 say they either pay for care on their own or get it free.

Three-fourths of persons who were uninsured at the time they were interviewed had been uninsured for at least one year. Only 8.9% lacked coverage for just one to three months. Longer durations of uninsurance are associated with lower family incomes.

Thus, the decline in employment-based health insurance affected all groups in California, but it fell more heavily on those with low incomes. Despite this decline in job-based insurance, California's overall uninsured rate remained constant due to significant growth in public coverage programs, particularly Medi-Cal and Healthy Families, and in privately purchased insurance.

EMPLOYMENT-BASED INSURANCE COVERAGE

Job-based coverage is still the foundation of California's health insurance system, albeit a crumbling one. A majority of nonelderly adults get their coverage through their own or a family member's employment, but the decline in employment-based health insurance in 2003 suggests that the long-term erosion of this foundation will continue.

It is noteworthy that *the decline in job-based coverage for adults in 2003 occurred entirely among those who had coverage through a family member's employment (dependent coverage), and that the proportion of adults who received health insurance through their own employer (primary coverage) remained stable.* In 2003, 14.5% of all nonelderly adults had all-year employment-based health insurance as a dependent, down 2.2 percentage points from 2001, while the rate of all-year job-based primary coverage was statistically unchanged.

The proportion of workers whose employers offered coverage (offer rate) increased between 2001 and 2003, but the proportion who were eligible for health benefits (eligibility rate) decreased. The rising offer rate was partially offset by a decline in the eligibility rate, leaving the proportion of employees who have access to job-based insurance statistically unchanged. Among employees with access to health benefits (that is, those who were both offered and eligible for them), 85% took up their employer's offer of coverage (take-up rate), an increase of 1.7 percentage points in 2003.

The increase in the offer rate seems paradoxical because, during this period, unemployment rose from 5.4% to 6.7%, a condition that typically reduces pressure on employers to offer health benefits. However, it is likely that the apparent increase in the offer rate is actually due to more jobs that did not provide health benefits being lost than the number of jobs that provided benefits, so that a larger proportion of workers was employed by an employer that offered health insurance.

The sharp decline in dependent coverage through employment is likely due to a 79.1% increase between 2001 and 2003 in the average cost to employees for family coverage, which was already far more costly than individual coverage. The reason for the increased take-up rate, in the face of rising costs for both single and family coverage, may be that as working spouses lost employment and access to dependent coverage, more of those who were eligible accepted their own employer's health benefits.

A total of 3.6 million California employees did not have access to health insurance through their own job in 2003. Only 5.8% of employees who did not have any employment-based coverage had a spouse with access to insurance through his or her own job.

Among *uninsured* employees who were eligible for their employer's plan, the largest proportion (45.3%) reported they did not take up the plan because they could not afford the cost of the health benefits. Only 14.7% of eligible uninsured employees reported they did not take up their employer's coverage because they did not need or want health insurance.

GROWTH IN THE MEDI-CAL AND HEALTHY FAMILIES PROGRAMS FROM 2001 TO 2003

Between 2001 and 2003, the growth in enrollment in Medi-Cal and Healthy Families offset much of the loss in job-based coverage.

Both Medi-Cal and Healthy Families increased their retention of children in these programs. Approximately 90% of children who were enrolled in Medi-Cal or Healthy Families at the time of the CHIS interview had been in the program continuously for at least the previous 12 months.

Although nearly half of children who were enrolled in Medi-Cal or Healthy Families had at least one parent also enrolled in one of these programs, a quarter had at least one parent with employer-based coverage, and another quarter had parents who were both uninsured. Half of children in Medi-Cal or Healthy Families had at least one parent who was a full-time employee, and another 15% had at least one parent who was employed part-time or was self-employed.

Among children who were uninsured at the time of the CHIS interview, 55%—429,000 in all—were eligible for Medi-Cal or Healthy Families. This was a significant drop from 2001, when over 650,000 were uninsured but eligible for either program. The change represents both the decline in the overall number of uninsured children and the success of public programs in enrolling previously uninsured children through outreach services. Still, over half of uninsured children who are eligible for Medi-Cal or Healthy Families had been completely uninsured for all of the previous 12 months.

Among children who were uninsured but eligible for Medi-Cal or Healthy Families, seven in 10 had parents who were themselves uninsured. The remainder had parents who were covered by job-based or privately purchased insurance.

California enacted—and the federal government approved—extending eligibility for Healthy Families to parents of children enrolled in the program, but this policy has not been implemented due to funding shortages. If this policy were implemented, 377,000 uninsured parents could receive coverage, 9.2% of all uninsured adults. Among uninsured adults overall, only 6% are themselves eligible for Medi-Cal; this represents nearly 250,000 adults, mostly parents of Medi-Cal enrollees, who could gain coverage if they were enrolled.

Parents reported a variety of reasons as to why their uninsured children who are eligible for Medi-Cal or Healthy Families are not enrolled in the programs. Nearly one-third of parents of those eligible for Medi-Cal said they didn't think their children were eligible for the program. Among parents of children who are uninsured but eligible for Healthy Families, only one in 10 reported they didn't know the program existed, down 12.3 percentage points from 2001.

Thus, between 2001 and 2003, Medi-Cal and Healthy Families succeeded in enrolling and retaining a much larger portion of uninsured children who were eligible for the programs. For the Healthy Families program, these significant changes reflected a continuing maturation of the program and an increasing knowledge of it among parents.

THE ACCESS AND HEALTH CONSEQUENCES OF COVERAGE

Periods of intermittent or continuous uninsurance have serious consequences for an individual's access to important health care services. For persons with insurance, access is also affected by the type of coverage they have.

Children who were uninsured all or part year were twice as likely as those on Medi-Cal all year and three times more likely as those with employer-based coverage all year to lack a usual or regular source of medical care. Three-quarters of children with employer-based coverage report having a doctor's office or HMO as their usual source of care, compared to less than half of those with Medi-Cal coverage all year and only two in five uninsured children.

These differences in usual sources of care across insurance types were even more dramatic among nonelderly adults. Adults who were uninsured all or part of the year were three times more likely than those with Medi-Cal coverage all year and six times more likely than those with employer-based coverage all year to have no usual source of care. More than eight in 10 adults with employer-based coverage throughout the year reported having a doctor's office or HMO as their usual source of care, but only about half of adults with all-year Medi-Cal coverage and only three in 10 uninsured adults relied on a doctor's office or HMO for care.

A larger proportion of adults and children experienced delays in getting a prescription or any other medical care in 2003 than in 2001. These changes affected persons with Medi-Cal, Healthy Families, and employment-based coverage, as well as those who were uninsured all or part year.

Among adults, those with employer-based or Medi-Cal coverage all year were more likely to receive recommended cancer screening than adults who were uninsured all or part of the year. For example, eight out of 10 women ages 40 and over with employer-based coverage all year and seven out of 10 with Medi-Cal coverage all year reported a mammogram within the past two years, compared to just over half of women who were uninsured all year. In addition, compared to adults who were uninsured all year, adults with all-year Medi-Cal coverage or all-year employer-based coverage were much more likely to be taking medication to help control their chronic conditions, such as asthma, diabetes and high blood pressure.

Adults' satisfaction with care varied across insurance types, with the uninsured seemingly least satisfied with their care. Overall, a higher proportion of adults had a difficult time seeing a specialist and receiving necessary health care if they were either uninsured all or part of the year or had Medi-Cal coverage all year, and this was especially true for adults with chronic conditions.

Latino, African-American, and American Indian/Alaska Native adults were four or more times as likely as white adults to report that they would have received better care if they were of a different racial/ethnic group, a finding that is consistent with the findings of the Institute of Medicine's report, *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care.*[1]

WHERE DO WE GO FROM HERE?

Employment-based health insurance has declined recently due to the contraction of the nation's and California's economy and to the continuing rapid growth in health insurance costs. Rising health care costs—which have outstripped the ability of many workers and employers to afford health insurance premiums—have been the major cause of a long-term decline in job-based coverage.

1 Institute of Medicine. *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care.* Washington, DC: National Academy Press, 2002.

Recent trends toward high-deductible health plans are likely to exacerbate the already large problem of underinsurance for millions of Americans, including California residents. More effective steps need to be taken to slow the growth in health care costs, steps that could begin with implementation of AB 1528, enacted in 2003, and the creation of the "California Health Care Quality Improvement and Cost Containment Commission."

Covering Uninsured Children. The problems in California's and the nation's health insurance arrangements continue to grow, despite the decline in uninsurance for children in California between 2001 and 2003. The decline in children's uninsured rate is a result primarily of expanded coverage for children through Medi-Cal and Healthy Families, which generate federal matching funds. The effective expansion of enrollment in these programs was the result of California enacting expanded eligibility for children. This was a broad legislative and advocacy commitment to make these programs work more effectively by simplifying administrative eligibility provisions, continuous fine-tuning of state and local public policies to make them more "family friendly," and the vigorous implementation of these programs and policies by State and local public agencies, coalitions of children's advocacy and health care groups, and philanthropic foundations.

Recently, local "Healthy Kids" coalitions in more than two dozen counties have brought together county health departments, county-sponsored health plans, First 5 county commissions, advocates and foundations to develop locally sponsored health insurance programs that fill in the gaps left by other public programs. By April 2005, local Healthy Kids programs covered 75,000 children who did not qualify for Medi-Cal or Healthy Families, but these efforts are not sustainable without State or federal support.

A proposal by two advocacy coalitions would create a State eligibility standard for children's public coverage that matches the standard set by county Healthy Kids programs. This would be an effective policy to complete the goal of covering all California children.

Covering Uninsured Adults. California has yet to take any significant steps to help the 5.6 million uninsured adults find affordable coverage. One small and relatively simple step would be to implement the approved, but not yet funded, Healthy Families expansion to cover eligible parents of children who are enrolled in Healthy Families, a step that would extend coverage to 377,000 uninsured adults. Beyond this, California needs to take some much bolder steps to address this very large and growing uninsured population. Three policy options have received a lot of attention.

Pay-or-Play. SB 2, enacted in 2003, would have established a "pay-or-play" requirement that would have compelled employers with 50 or more workers to provide health benefits to eligible employees or to pay into a State-administered fund that would contract for mandated coverage. Opponents of pay-or-play succeeded in putting a referendum on the November 2004 election ballot, Proposition 72. The 50.9% vs. 49.1% vote repealed SB 2, but the less than one percent loss suggests that pay-or-play may have strong political legs as a means to assure health insurance coverage to California workers.

Individual Coverage Mandate. A 2005 legislative proposal, AB 1670, would require every individual to maintain basic health care insurance. Every Californian would be required to provide evidence of coverage by at least a high-deductible health plan (with deductibles up to $5,000) that includes preventive care coverage. Although the bill died, the authors have vowed to resubmit it in the next session. Enacting a requirement that all individuals must participate in the health insurance coverage system would establish a critically important element that is needed to achieve coverage of the entire population.

But AB 1670 also has some significant limitations. Although AB 1670 is a thoughtful attempt to move the political process toward dramatically reducing the number of uninsured, it would require far greater tax-funded subsidies than the bill provided. In addition, it would be likely to have the unintended effect of accelerating the erosion of comprehensive insurance coverage, increasing the financial exposure of more Californians and likely increasing the rate of medically related personal bankruptcies.

Single-Payer Health Care. A third option is to replace the fragmented private health insurance system with a publicly run "single-payer" health care system that would provide coverage to all Californians. The current single-payer bill, SB 840 (in the previous session, it was SB 921), would replace all deductibles and premiums paid to private health insurance companies with taxes paid to a government-run health care trust fund, and the government would become the single payer of all health insurance costs. There is considerable evidence that a single-payer system would dramatically reduce the high administrative costs of the current system and that the enormous purchasing power of such a state program would enable it to reduce the costs of prescription drugs and medical devices.

There are many attractive features of a single-payer system. First, it would sever the dependence of health insurance on employment so that, as workers change or lose jobs, their health insurance coverage and that of their family would not be affected. Second, a single-payer system would facilitate more effective cost control. Third, it would reduce the frequent confusion that families and health professionals face about which health care services are covered and which are not.

Nevertheless, a number of serious criticisms have been leveled against single-payer proposals. A single-payer system creates the conditions for more accountability to the public's interests, but the controlling executive and legislative branches of government are subject to political influence that can constrain the efficiency and effectiveness of a public agency, often on behalf of the special interests that deal with the subordinate government agency. In addition, the political challenges of enacting it are formidable as it has been difficult to persuade the public that they might spend less overall because their higher taxes could be more than offset by larger take-home wages when employers no longer have to pay the additional fringe benefits associated with employer-based health insurance.

Conclusion. Bold steps are needed to both cover the uninsured and to effectively control the growth in health care costs for all income groups. Until California or the United States as a whole adopts effective controls over health care spending, we can expect to see a continuing, and even accelerating, erosion of employment-based insurance.

There are some valuable immediate and longer-term steps that California can take to cover the uninsured. Expanding coverage for children represents the relatively low-hanging fruit because it is relatively modest and builds on the longstanding commitment of State and Federal policy makers—and the public—to assure health insurance and access to care for all children. Additional measures that would cover adults are more challenging, both fiscally and politically. The dialogue created by pay-or-play, the proposal for an individual mandate, and the proposed single-payer system offer an opportunity to engage the public in a fruitful dialogue and begin building a political consensus on the direction that California should take to insure all of its residents.

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Despite the contributions of all these colleagues, without whom this report would not have been possible, any errors or omissions are the responsibility of the authors.

1. AN OVERVIEW OF HEALTH INSURANCE COVERAGE IN CALIFORNIA

More than one in five nonelderly Californians (21%) experienced lack of coverage in 2003—nearly 6.6 million persons in all (Exhibit 1). California has more uninsured residents than the entire population of the state of Massachusetts. More than 3.7 million were without any coverage for at least 12 months.

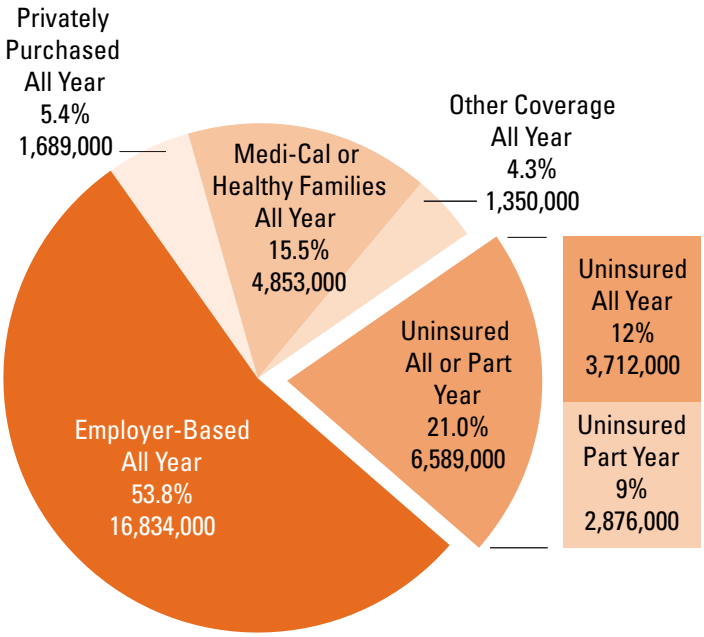
Based on data from the 2003 California Health Interview Survey (CHIS 2003), this report offers a detailed picture of nonelderly Californians' health insurance coverage and lack of coverage. The report also provides a discussion of employer-based insurance and the coverage of employees statewide, estimates of children and adults who are uninsured but eligible for coverage through public programs, the consequences of not having coverage, and an examination of policy options to expand coverage to the uninsured. It also describes how this profile has changed since 2001, based on data from CHIS 2001.

6.6 MILLION UNINSURED IN 2003

In 2003, just over half of nonelderly Californians were covered throughout the year by employment-based health insurance (53.8%). Another 15.5% were covered by Medi-Cal or the Healthy Families Program for the entire year, including 4.3 million (13.8%) who had Medi-Cal all year and 531,000 (1.7%) who had Healthy Families all year. (These numbers represent persons who were enrolled the entire year in each type of coverage and exclude those who had that coverage for less than a full year.) Another 5.4% were covered by a privately purchased health plan throughout the year, and another 4.3% had some other coverage all year (such as Medicare, another public program, or a combination of different private and/or public sources).

In addition to uninsured nonelderly residents, 21,000 Californians age 65 and over also were uninsured (data not shown). However, they represent only 0.1% of all elderly residents, nearly all of whom are otherwise covered by at least Medicare, the virtually universal federal program for

EXHIBIT 1. HEALTH INSURANCE COVERAGE DURING THE LAST 12 MONTHS, AGES 0-64, CALIFORNIA, 2003



Note: The category "other coverage all year" includes all-year government-sponsored programs that are not Medi-Cal or Healthy Families, as well as any combinations of insurance over the course of 12 months during which the person was never uninsured.

Source: 2003 California Health Interview Survey

the elderly and many nonelderly disabled adults. Although many elderly residents are underinsured, particularly for long-term care, prescription drug coverage and catastrophic expenses, this report focuses on the nonelderly population, which accounts for nearly all of the uninsured.

CHILDREN AND ADULTS LOSE JOB-BASED INSURANCE

More than 5.6 million nonelderly adults—one in four in this age group—experienced lack of coverage for some or all of the year in 2003. Both the percent of adults who were uninsured all of the year and the percent uninsured part of the year were statistically unchanged in 2003 compared to 2001, despite a slight apparent increase in uninsurance (Exhibit 2).

Nearly a million California children under age 18—one in 10 of the state's children—were uninsured for all or part of the year in 2003, but this represented a substantial decrease from 2001. The percent who were uninsured all of the year fell 2.5 percentage points in 2003 compared to 2001, and the percent of those uninsured part of the year declined 1.2 percentage points (Exhibit 2).

Adults and children both lost employer-based insurance in 2003. Nearly half of adults (54.5%) had job-based insurance all year, two percentage points lower than in 2001 (Exhibit 2).

This drop in employment-based coverage was due to a slack labor market, which has not fully recovered, and rapidly rising costs of health insurance, which continue to grow far faster

EXHIBIT 2. AGE GROUP BY HEALTH INSURANCE COVERAGE DURING LAST 12 MONTHS, AGES 0-64, CALIFORNIA, 2001 AND 2003

	UNINSURED ALL YEAR		UNINSURED PART YEAR		EMPLOYMENT-BASED ALL YEAR		MEDI-CAL OR HEALTHY FAMILIES ALL YEAR		OTHER ALL YEAR		TOTAL
AGE GROUP	2003	CHANGE FROM 2001[i]	2003	CHANGE FROM 2001	2003	CHANGE FROM 2001	2003	CHANGE FROM 2001	2003	CHANGE FROM 2001	2003
AGES 0-17	4.5 430,000	– 2.5**	5.7 542,000	– 1.2**	52.1 4,947,000	– 3.9**	29.4 2,787,000	+ 5.0**	8.3 782,000	+ 2.6**	100% 9,488,000
AGES 18-64	15.0 3,282,000	+ 0.2	10.7 2,335,000	+ 0.1	54.5 11,887,000	– 2.1**	9.5 2,066,000	+ 0.5	10.3 2,257,000	+1.3**	100% 21,827,000
AGES 0-64	11.9 3,712,000	– 0.5*	9.2 2,876,000	– 0.3	53.7 16,834,000	– 2.6**	15.5 4,853,000	+ 1.8**	9.7 3,039,000	+ 1.7**	100% 31,315,000

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

Note: "Other All Year" includes all-year privately purchased insurance and other government-sponsored programs that are not Medi-Cal or Healthy Families, as well as any combinations of insurance over the last 12 months during which the person was never uninsured.

i Change in percentage points, not in the percent of the total estimate. Change is from reweighted 2001 California Health Interview Survey.

* Change is statistically significant at $p < 0.1$.

** Change is statistically significant at $p < 0.05$.

Source: 2001-R and 2003 California Health Interview Surveys

than inflation. California's average monthly unemployment rate rose from 5.4% in 2001 to 6.8% in 2003,[2] decreasing the proportion of Californians with access to job-based insurance and depressing workers' ability to make wage and benefit demands on employers. At the same time, the cost of employment-based health insurance premiums rose dramatically, with the average total cost of a single coverage plan in California rising 31.6% between 2001 and 2003 and the average for family coverage rising 36.1%.[3]

Children also lost health insurance obtained through their parent's employment. Children's all-year employment-based insurance fell 3.9 percentage points between 2001 and 2003 (Exhibit 2). The greater drop in children's employment-based coverage is probably due to the especially sharp increase in the average employee costs for family coverage. The average worker's contribution for family coverage plans in California jumped from $114.08 per month in 2001 to $204.33 in 2003—an increase of 79.1% and more than twice the percentage increase in the average total cost of such plans—as employers shifted more of the costs to their workers. Workers' average contributions for single-person coverage rose 65.2%.[4] Although the increase in out-of-the-paycheck contributions of workers for single-person coverage was nearly as large for family coverage, the single-person cost began from a much lower and more heavily subsidized starting point.

About one in 10 adults (9.5%) was covered all year by Medi-Cal or Healthy Families, an increase of only half a percentage point from 2001 to 2003. In contrast, 29.4% of children were covered all year by Medi-Cal or Healthy Families, an increase of five percentage points from 2001. Children's enrollment in these public programs reflects the much broader eligibility levels for children than adults, and the extensive efforts and resources invested in outreach and enrollment by State and local agencies, voluntary organizations, and local children's health insurance expansion programs. It also reflects the effects of full implementation of California's continuous eligibility for children in Medi-Cal, dramatically increasing retention of eligible children and reducing their loss of coverage.

Children's "other" coverage all year rose by 2.6 percentage points from 2001, while adults' other coverage increased by a slightly smaller amount. This grouping includes about 412,000 children who were covered by a privately purchased health plan throughout the year in 2003, up from 245,000 in 2001, and 1,278,000 adults with privately purchased insurance in 2003, up from 1,207,000 in 2001. In addition, thousands of children were covered by recently developed county-based expansion programs, which are designed to fill in the gaps left by Medi-Cal and Healthy Families, but almost none of which are available to adults. As of March 2005, about 71,000 Californians were covered by these programs (based on administrative data).[5]

2 Annual Unemployment Rate, California, *http://www.labormarketinfo.edd.ca.gov/cgi/dataanalysis/labForceReport.asp?menuchoice=LABFORCE*.

3 Kaiser Family Foundation and the Health Research Educational Trust, *California Employer Health Benefits Survey, 2003*, Menlo Park, CA: Henry J. Kaiser Family Foundation, March 2004; and *California Employer Health Benefits Survey 2004*, Oakland: California HealthCare Foundation and the Health Research and Educational Trust, 2004.

4 Kaiser Family Foundation and the Health Research Educational Trust, *California Employer Health Benefits Survey, 2003*, and *California Employer Health Benefits Survey 2004*.

5 Institute for Health Policy Solutions, *www.ihps.org*, accessed 4/04/05.

EXHIBIT 3. DETAILED AGE GROUP BY HEALTH INSURANCE COVERAGE DURING LAST 12 MONTHS, AGES 0-64, CALIFORNIA, 2001 AND 2003

	UNINSURED ALL YEAR		UNINSURED PART YEAR		EMPLOYMENT-BASED INSURANCE ALL YEAR		MEDI-CAL OR HEALTHY FAMILIES ALL YEAR		OTHER ALL YEAR		TOTAL
AGE GROUP	2003	CHANGE FROM 2001[i]	2003	CHANGE FROM 2001	2003	CHANGE FROM 2001	2003	CHANGE FROM 2001	2003	CHANGE FROM 2001	2003
AGES 0-11	3.3 206,000	-2.7**	5.8 361,000	-0.9*	50.3 3,132,000	-4.4**	32.2 2,007,000	+5.6**	8.4 524,000	+2.4**	100% 6,229,000
AGES 12-17	6.9 224,000	-2.1**	5.5 181,000	-1.7**	55.7 1,815,000	-3.1**	23.9 781,000	+4.1**	7.9 259,000	+2.9**	100% 3,260,000
AGES 18-29	20.4 1,197,000	+0.5	18.6 1,095,000	+0.2	36.5 2,144,000	-3.8**	12.6 741,000	+1.6**	11.9 698,000	+1.5**	100% 5,874,000
AGES 30-39	15.4 837,000	0.0	11.7 637,000	+0.9	57.1 3,098,000	-1.9*	8.2 447,000	+0.3	7.6 411,000	+0.8	100% 5,430,000
AGES 40-49	13.3 706,000	+0.7	6.8 362,000	0.0	62.3 3,295,000	-2.7**	8.3 440,000	+0.8	9.2 489,000	+1.1*	100% 5,292,000
AGES 50-64	10.4 543,000	0.0	4.6 241,000	-0.2	64.0 3,350,000	-0.7	8.4 438,000	-0.9*	12.6 660,000	+1.8**	100% 5,231,000

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

i Change in percentage points, not in the percent of the total estimate. Change is from reweighted 2001 California Health Interview Survey.

* Change is statistically significant at $p < 0.1$.

** Change is statistically significant at $p < 0.05$.

Source: 2001-R and 2003 California Health Interview Surveys

YOUNG ADULTS HAVE HIGHEST UNINSURED RATE

Uninsured rates are lowest among children; they rise dramatically among 18 to 29 year olds, and then decline to age 64. The uninsured rates for each age group are driven by their employment-based insurance coverage.

Children under age 12 have the lowest uninsured rate, and few are without coverage all year. Like adults in all age groups, these young children lost coverage through their parent's employment-based insurance between 2001 and 2003, but far more than other age groups, young children's all-year coverage in Medi-Cal and Healthy Families rose dramatically—up 5.6 percentage points (Exhibit 3). The pattern for children ages 12-17 were very similar, albeit not as dramatic. Both groups also gained privately purchased coverage and coverage through several county-sponsored health insurance expansion programs.

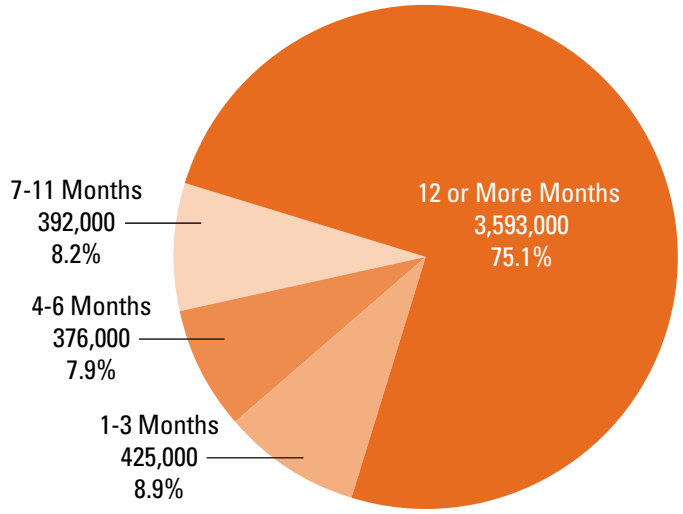
Young adults, ages 18-29, face very different circumstances. Four in 10 are uninsured all or some of the year, well above all other age groups. In 2003, 20.4% were uninsured all year and another 18.6% were uninsured part of the year. Their high uninsured rate is due to their having the lowest rate of employment-based health insurance: 36.8% in 2003, down

3.8 percentage points from 2001. The reasons for their low rate of coverage are directly related to their tenuous connection to the labor market: entry-level jobs, part-time or part-year work and low wages. There is little direct evidence to support widely held assumptions that young adults do not want or value health insurance, a point to which we will return in the next section of this report.

Employment-based coverage also fell for adults age 30 and over. However, as a result of small (mostly non-significant) increases in Medi-Cal, privately purchased health insurance and other public sources of coverage, their level of uninsurance did not change significantly.

Employment-based coverage was statistically unchanged for adults ages 50 to 64, although it showed a downward trend as for other age groups. The percent and numbers in this age group that are uninsured all year or part year are relatively small—the smallest percent among all adult age groups—but the 782,000 who were uninsured, on average, face significantly greater health challenges than the average adult below that age.

EXHIBIT 4. DURATION OF UNINSURANCE AMONG PERSONS UNINSURED AT TIME OF INTERVIEW, AGES 0-64, CALIFORNIA, 2003



Note: Numbers may not add to 100% due to rounding.
Source: 2003 California Health Interview Survey

LACK OF INSURANCE IS A VERY DURABLE STATUS

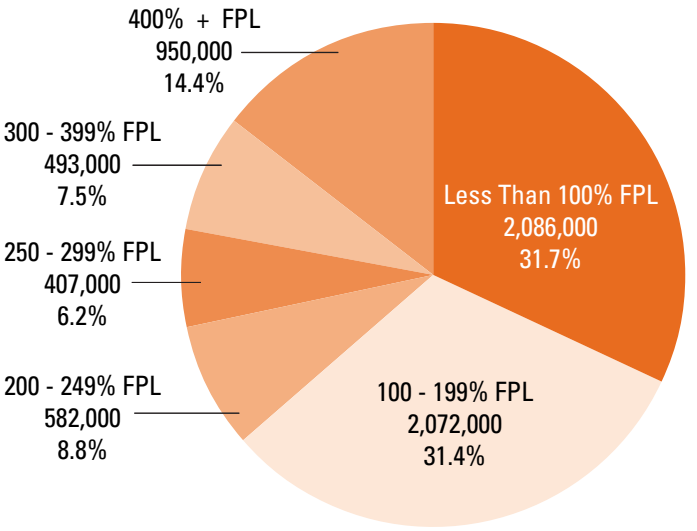
Few of the uninsured could be characterized as short-term uninsured.

Three-fourths (75.1%) of persons who were uninsured at the time they were interviewed for CHIS 2003 were without coverage for a year or longer (Exhibit 4). Another 8.2% were uninsured for seven to 11 months. Just 8.9% lacked coverage for just one to three months—the group that could be characterized as the short-term uninsured. These findings are consistent with the results of other studies about duration of uninsurance.[6]

Longer durations of uninsurance are associated with lower family incomes. Seven in 10 persons (71%) who have been uninsured for a year or more have family incomes below 200% of the federal poverty level (FPL), compared to about half (51-53%) of those whose lack of coverage is more short-term (less than one year; data not shown).

6 Congressional Budget Office, *How Many People Lack Health Insurance and For How Long?* Washington, DC: Congressional Budget Office, May 2003; and Haley J, Zuckerman S, *Is Lack of Coverage a Short- or Long-Term Condition?* Washington, DC: Kaiser Commission on Medicaid and the Uninsured, June 2003.

EXHIBIT 5. FAMILY INCOME AMONG THE UNINSURED, AGES 0-64, CALIFORNIA, 2003



Note: Numbers may not add to 100% due to rounding.
Source: 2001-R and 2003 California Health Interview Surveys

UNINSURED OVERWHELMINGLY HAVE LOW INCOMES

The great majority of uninsured Californians have very low incomes. Among the 6.6 million adults and children who were uninsured all or part of the year, 4.2 million (63.1%) had family incomes below 200% FPL (Exhibit 5)—that is, less than $30,000 a year for a family of three in 2003. By comparison, 37.2% of non-elderly Californians had family income below 200% FPL. Among these uninsured persons, 51.9% had no family member who worked for an employer that offered health benefits to employees (data not shown). However, 19.9% had a family member with job-based insurance (data not shown). Many of these low-income uninsured adults and children may have had access to dependent coverage; but, given their incomes, it is very likely that any such available coverage was not affordable, a point to which we will return in Chapter 2.

Only 21.9% of uninsured adults and children have family incomes at least 300% FPL, whereas half of all nonelderly Californians have incomes above that level. Approximately 950,000 have family incomes at least 400% FPL (nearly $59,000 a year for a family of three). Nearly half of the uninsured above 300% FPL had a family member who had job-based insurance (data not shown), suggesting that for many, dependent coverage might be available and might be affordable.

The very low incomes of the uninsured underscore the need for extensive subsidies to make health care coverage affordable to them. Even at 400% of the poverty level, health insurance premiums can be a real financial stretch if insurance is not available through employment or if the required employee share of premiums is not affordable.

JOB-BASED INSURANCE DECLINED MUCH MORE AMONG LOWER INCOME GROUPS

The decline in job-based coverage between 2001 and 2003 hit all income groups, but it fell by much more among lower income Californians than among those with higher incomes. Employment-based coverage plummeted among Californians with income between 100 and 199% FPL, falling from 38.4% in 2001 to 30.9% in 2003 (Exhibit 6). Just 11% of those with family incomes below poverty and only 30.9% of those with incomes just above poverty had job-based insurance throughout the year in 2003. If job-based insurance continues to decline at that rate for those below 200% FPL, very few

low-income workers will have employment-based coverage. Job-based insurance also declined substantially for those between 200-299% FPL, dropping to 55.8% of this income group. In contrast, job-based insurance declined just 1.2 percentage points among those in families with incomes at least 300% FPL, leaving more than three-fourths (77.5%) with employment-based insurance throughout the year.

Less than one in 10 persons with incomes of 300% FPL or more experienced lack of coverage during the year. In contrast, nearly four in 10 people below poverty were uninsured for at least part of 2003, including 24.6% who were uninsured during the entire year.

Among persons with family incomes at least 400% of the poverty level, 81% had job-based insurance throughout the year. Just 4% were uninsured for part of the year and 3% were uninsured all year (data not shown).

Adults were much more likely than children to be uninsured for all or part of the year in 2003 among families below the poverty level. And, while the uninsured rate for adults living in poverty increased between 2001 and 2003, the uninsured rate for children below poverty rate *dropped* by a stunning 6.9 percentage points (data not shown). This dramatic difference between poor adults and children is the result of children's eligibility for and enrollment in Medi-Cal and

EXHIBIT 6. FAMILY INCOME AS A PERCENT OF THE FEDERAL POVERTY LEVEL BY HEALTH INSURANCE COVERAGE DURING LAST 12 MONTHS, AGES 0-64, CALIFORNIA, 2001 AND 2003

	UNINSURED ALL YEAR		UNINSURED PART YEAR		EMPLOYMENT-BASED INSURANCE ALL YEAR		MEDI-CAL OR HEALTHY FAMILIES ALL YEAR		OTHER ALL YEAR		TOTAL
HOUSEHOLD INCOME	**2003**	**CHANGE FROM 2001[i]**	**2003**	**CHANGE FROM 2001**	**2003**	**CHANGE FROM 2001**	**2003**	**CHANGE FROM 2001**	**2003**	**CHANGE FROM 2001**	**2003**
< 100% FPL	24.6	– 1.1	13.5	– 0.6	11.0	– 1.9**	44.8	+ 2.3*	6.1	+ 1.2**	100% 5,468,000
100-199% FPL	20.6	– 1.1	13.0	+ 0.5	30.9	– 7.5**	27.1	+ 6.8**	8.4	+1.3**	100% 6,162,000
200-299% FPL	11.3	– 0.1	11.9	+ 1.5*	55.8	– 5.5**	10.1	+ 1.6**	10.9	+ 2.5**	100% 4,269,000
300%+ FPL	4.0	+ 0.1	5.4	– 0.9**	77.5	– 1.2**	2.0	+ 0.2	11.2	+ 1.7**	100% 15,416,000

FPL = Federal Poverty Level

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

Note: The 2003 FPL was $9,573 for one person, $12,384 for a two-person family and $14,680 for a three-person family. *http://www.census.gov/hhes/poverty/threshld/thresh03.html* (accessed November 22, 2004).

i Change in percentage points, not in the percent of the total estimate. Change is from reweighted 2001 California Health Interview Survey.

* Change is statistically significant at $p < 0.1$.

** Change is statistically significant at $p < 0.05$.

Source: 2001-R and 2003 California Health Interview Surveys

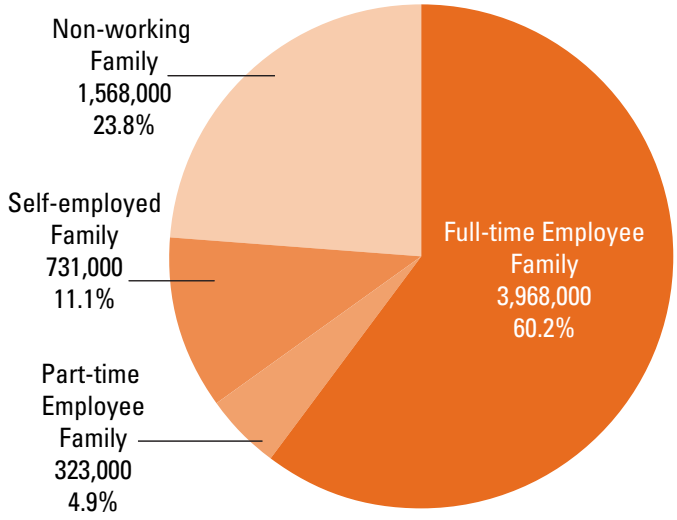
Healthy Families, not differences in access to job-based insurance. Many of the children in families between 100 and 199% of poverty also received coverage from Medi-Cal or Healthy Families, offsetting their loss of employment-based coverage.

THREE OUT OF FOUR UNINSURED IN WORKING FAMILIES

The uninsured are overwhelmingly a working population. Three out of four are workers and their spouses and children (Exhibit 7), including four million (60.2%) who were in families headed by at least one adult who worked full time for an employer.[7] Over one million more were part-time employees and their dependents, or self-employed workers and their families.

Employment status was similar for people who were uninsured all year and those who were uninsured part of the year. However, persons in families headed by a self-employed worker were much more likely to be uninsured all year: 19% were uninsured all year compared to 10% of those in families headed by a full-time employee (data not shown).

EXHIBIT 7. CURRENT FAMILY WORK STATUS AMONG THOSE UNINSURED ALL OR PART OF LAST 12 MONTHS, AGES 0-64, CALIFORNIA, 2003



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

Note: The time frame for work status is "last week." "Full-time Employee Family" includes at least one full-time worker; "Part-time Employee Family" includes at least one part-time worker and no full-time workers; "Self-employed Family" includes at least one person who is self-employed and no employees; "Non-working Family" includes persons in families with no working adult (includes unemployed, students, retired, or temporarily or permanently disabled persons).

Source: 2003 California Health Interview Survey

The great majority of these working uninsured had no access to employment-based insurance coverage because they either worked for an employer that did not offer health insurance, or they were not eligible for benefits from their employer. Many others could not afford the required employee share of cost. The issue of workers' access to affordable health insurance is addressed more fully in Chapter 2.

Among adults and children who were uninsured some or all of the year, one-quarter were not themselves working at the time they were interviewed or they were in a family with no working adult. Among non-working adults in this group, 35% were keeping house or caring for children or another family member, 17% were physically disabled or otherwise unable to work, 12% were students, and 11% were unemployed, on layoff or on strike (data not shown).

7 Work status, as defined in the CHIS interview, is a current point-in-time measure. Therefore, CHIS estimates of non-working families could include persons who were not working when interviewed but had worked sometime during the previous year. In comparison, the Current Population Survey (CPS) also measures work status but asks about work over the entire calendar year, thus capturing part-year workers; using CPS data, persons in non-working families comprised 17.3% of the uninsured in California in 2003. Please see the Appendix for a detailed discussion of comparing CHIS and CPS.

Interestingly, the reasons given for not being insured vary little by family work status, except for reasons related to employment itself (and these are examined more fully in Chapter 2). The main reason that uninsured persons give for not having coverage is that "I can't afford it" (43%), with little variation by family work status, except that among those in self-employed families, 60% said they can't afford it. About 8% believed they were not eligible due to citizenship or immigration status, 7% said their attempts to get coverage were denied for health or other reasons, and 2% said they lost public program coverage, such as Medi-Cal. Only 8% said they don't have health insurance because they are healthy and don't need it or don't believe in it, and another 2% said they either pay for care on their own or get it free (data not shown).

LOSS OF JOB-BASED INSURANCE HIT ALL RACIAL/ETHNIC GROUPS

All racial/ethnic groups lost job-based coverage between 2001 and 2003. The proportion of whites with employment-based insurance throughout the year declined 2.4 percentage points, reflecting the loss of job-based insurance for nearly 300,000 white adults and children. But whites continued to have the highest rate of employment-based coverage at 66.6% (Exhibit 8), and the lowest uninsured rate for any racial/ethnic group.

EXHIBIT 8. RACIAL/ETHNIC GROUP BY HEALTH INSURANCE COVERAGE DURING LAST 12 MONTHS, AGES 0-64, CALIFORNIA, 2001 AND 2003

	UNINSURED ALL YEAR		UNINSURED PART YEAR		EMPLOYMENT-BASED INSURANCE ALL YEAR		MEDI-CAL OR HEALTHY FAMILIES ALL YEAR		OTHER ALL YEAR		TOTAL
RACIAL/ETHNIC GROUP	2003	CHANGE FROM 2001[i]	2003	CHANGE FROM 2001	2003	CHANGE FROM 2001	2003	CHANGE FROM 2001	2003	CHANGE FROM 2001	2003
WHITE	6.0	– 0.3	7.2	– 0.7**	66.6	– 2.4**	7.7	+ 1.5**	12.6	+ 1.9**	100% 14,403,000
LATINO	21.9	– 1.9**	12.8	– 0.1	33.9	– 1.9**	26.1	+ 2.6**	5.2	+ 1.3**	100% 9,764,000
ASIAN AMERICAN AND PACIFIC ISLANDER	9.6	– 1.1	7.2	– 0.9	58.5	– 2.5*	12.3	+ 1.5*	12.4	+ 2.9**	100% 3, 692,000
AFRICAN AMERICAN	8.1	+ 1.3	8.9	+ 1.7*	51.3	– 3.7**	24.9	– 0.9	6.9	+ 1.6**	100% 2,171,000
AMERICAN INDIAN/ ALASKA NATIVE	14.6	+ 1.1	11.4	+ 1.0	43.3	– 8.0**	21.6	+ 2.3	9.2	+ 3.7*	100% 412,000

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

Note: "Other single and multiple race" category data are not shown in this table.

i Change in percentage points, not in the percent of the total estimate. Change is from reweighted 2001 California Health Interview Survey.

* Change is statistically significant at $p < 0.1$.

** Change is statistically significant at $p < 0.05$.

Source: 2001-R and 2003 California Health Interview Surveys

EXHIBIT 9. LATINO ETHNIC GROUP BY HEALTH INSURANCE COVERAGE DURING LAST 12 MONTHS, AGES 0-64, CALIFORNIA, 2003					
LATINO ETHNIC GROUP	UNINSURED ALL OR PART YEAR	EMPLOYMENT-BASED INSURANCE ALL YEAR	MEDI-CAL OR HEALTHY FAMILIES ALL YEAR	OTHER ALL YEAR	TOTAL
MEXICAN	33.9	35.0	25.7	5.4	100% 8,707,000
SALVADORAN	46.2	28.6	22.6	***	100% 524,000
GUATEMALAN	41.7	29.4	24.4	***	100% 284,000
OTHER CENTRAL AMERICAN	32.6	42.9	18.7	***	100% 204,000
PUERTO RICAN	21.0	43.8	26.7	***	100% 132,000
SOUTH AMERICAN	28.3	53.6	11.9	6.2	100% 241,000
LATINO EUROPEAN	19.4	61.5	10.0	9.2	100% 289,000
OTHER LATINO	19.9	51.8	21.7	6.6	100% 232,000
TWO OR MORE LATINO TYPES	18.1	46.2	28.0	7.8	100% 1,054,000

Note: Numbers may not add to 100% due to rounding.
*** Estimate is unstable because coefficient of variation is above 30%.

Source: 2003 California Health Interview Survey

Latinos' low rate of all-year job-based insurance fell another 1.9 percentage points to 33.9%, the lowest rate among all groups (Exhibit 8). As a result of their low employment-based coverage, Latinos continue to have the highest uninsured rates: one in three was uninsured for some or all of 2003, including one in five (21.9%) who lacked coverage for at least 12 months, and another 12.8% were uninsured for part of the year.

Among Latinos in California, Salvadoran and Guatamalan adults and children had very high uninsured rates, the result of their very low rates of employment-based coverage (Exhibit 9). Other Central American and Mexican-origin Latinos also had very high uninsured rates, which were due to their low rates of job-based insurance.

The low job-based insurance rate for American Indian/Alaska Natives (AI/ANs) plummeted eight percentage points between 2001 and 2003 (Exhibit 8). One in four AI/ANs in California was uninsured during some or all of 2003, including 14.6% who were uninsured for at least 12 months and another 11.4% uninsured part of the year. Contrary to popular belief, most AI/ANs do not have access to the Indian Health Service

EXHIBIT 10. ASIAN ETHNIC GROUP BY HEALTH INSURANCE COVERAGE DURING LAST 12 MONTHS, AGES 0-64, CALIFORNIA, 2003

ASIAN ETHNIC GROUP	UNINSURED ALL OR PART YEAR	EMPLOYMENT-BASED INSURANCE ALL YEAR	MEDI-CAL OR OR HEALTHY FAMILIES ALL YEAR	OTHER ALL YEAR	TOTAL
FILIPINO	11.5	69.8	7.6	11.2	100% 1,013,000
CHINESE	17.4	60.6	9.2	12.8	100% 954,000
VIETNAMESE	22.2	39.2	29.1	9.5	100% 452,000
SOUTH ASIAN	8.7	69.7	6.9	14.8	100% 438,000
KOREAN	34.1	37.2	10.6	18.1	100% 344,000
JAPANESE	16.0	70.3	***	11.1	100% 268,000
OTHER SINGLE OR MULTIPLE ASIAN TYPE[i]	14.8	50.4	27.1	7.8	100% 384,000

Note: Numbers may not add to 100% due to rounding.
i Includes Southeast Asian, Cambodian, other Asian, and two or more Asian types.
*** Estimate is unstable because coefficient of variation is above 30%.
Source: 2003 California Health Interview Survey

medical clinics or hospitals, most of which are available only on tribal lands.

The employment-based insurance coverage of African Americans fell 3.7 percentage points between 2001 and 2003, driving up their uninsured rate. In 2003, 17% of African Americans were uninsured for part or all of the year (Exhibit 8).

Asian Americans and Pacific Islanders (AAPIs) also lost job-based insurance during this period (Exhibit 8), leaving 51.3% with employment-based coverage throughout the year. This loss was more than offset by increases in public and privately purchased coverage.

Asian ethnic groups vary dramatically in their health insurance coverage. One third of Koreans (34.1%) were uninsured all or part of the year in 2003, a result of their very low rate of employment-based insurance (37.2%) and in spite of their very high enrollment in privately purchased health insurance (Exhibit 10). Vietnamese had a similar rate of employment-based coverage (39.2%), resulting in a relatively high

uninsured rate of 22.2%, despite high rates of enrollment in Medi-Cal and Healthy Families. Filipinos, Japanese, South Asians (including Asian Indians and Pakistanis) and Chinese all had higher rates of job-based insurance and, consequently, relatively low uninsured rates. The Asian ethnic groups with higher rates of self-employment have low rates of job-based insurance (data not shown) and, unless they have sufficient income to obtain privately purchased health insurance or are protected by Medi-Cal and Healthy Families, they tend to have higher rates of uninsurance. It is noteworthy that the variation in insurance coverage among Asian ethnic groups illustrates the disparities that result from the dependence of health care coverage on employment and income.

MOST CITIZENSHIP GROUPS LOST JOB-BASED INSURANCE

Among adults, U.S.-born citizens lost job-based insurance in 2003, compared to 2001, as did noncitizens (Exhibit 11). The only group that did not lose coverage through employment was naturalized citizens. Approximately six in 10 citizens, whether U.S.-born or naturalized, had employment-based health insurance throughout the entire year. Some purchased health insurance on their own, pushing up the rates for "other coverage" throughout the year. The all-year uninsured rate for U.S.-born citizens edged up slightly but significantly.

Among adult noncitizens, their substantial losses of coverage left just 37% of noncitizens with green cards and only 19.1% of noncitizens without green cards covered by employment-

EXHIBIT 11. CITIZENSHIP AND IMMIGRATION STATUS BY HEALTH INSURANCE COVERAGE DURING LAST 12 MONTHS, AGES 18-64, CALIFORNIA, 2001 AND 2003

	UNINSURED ALL YEAR		UNINSURED PART YEAR		EMPLOYMENT-BASED INSURANCE ALL YEAR		MEDI-CAL OR HEALTHY FAMILIES ALL YEAR		OTHER ALL YEAR		TOTAL
CITIZENSHIP AND IMMIGRATION STATUS	**2003**	**CHANGE FROM 2001[i]**	**2003**	**CHANGE FROM 2001**	**2003**	**CHANGE FROM 2001**	**2003**	**CHANGE FROM 2001**	**2003**	**CHANGE FROM 2001**	**2003**
U.S.-BORN CITIZENS	8.9	+0.6*	9.6	-0.1	61.8	-2.0**	8.0	+0.1	11.7	+1.3**	100% 14,119,000
NATURALIZED CITIZENS	12.5	-1.6	8.2	-1.2	59.0	+0.4	9.9	-0.2	10.4	+2.5**	100% 3,155,000
NONCITIZENS WITH GREEN CARD	26.7	-2.0	13.6	+1.1	37.0	-3.5**	15.8	+4.0**	6.9	+0.4	100% 2,385,000
NONCITIZENS WITHOUT GREEN CARD	45.9	+1.2	18.6	+1.5	19.1	-3.8**	11.4	+0.1	5.0	+1.0	100% 2,167,000

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

i Change in percentage points, not in the percent of the total estimate. Change is from reweighted 2001 California Health Interview Survey.

* Change is statistically significant at $p < 0.1$.

** Change is statistically significant at $p < 0.05$.

Source: 2001-R and 2003 California Health Interview Surveys

based insurance. Noncitizens without green cards include undocumented immigrants as well as those who are legally residing in the United States with student visas, temporary work permits, and the like. More noncitizens with green cards were enrolled in Medi-Cal in 2003 than in 2001, most likely through emergency Medi-Cal.

Citizen children with U.S.-born parents and noncitizen children experienced substantial losses of employment-based coverage through their parents (Exhibit 12), but children in all family citizenship groups experienced significant increases in Medi-Cal and Healthy Families coverage, and those with citizen parents also significantly gained other insurance (mainly privately purchased). These sources of increased coverage offset the loss of job-based insurance, leading to significant drops in their uninsured rate. U.S.-citizen children whose parents do not have green cards and noncitizen children benefited greatly from expanded Medi-Cal and Healthy Families enrollment.

MOST REGIONS LOST JOB-BASED INSURANCE BUT ALL REGIONS INCREASED MEDI-CAL AND HEALTHY FAMILIES ENROLLMENT

Between 2001 and 2003, Los Angeles County and the Central Coast were the only regions that did not experience a drop in job-based insurance. All regions achieved an increase in enrollment in Medi-Cal and Healthy Families, offsetting most of the decline in employment-based coverage (Exhibit 13).

Starting from the top of the state and moving south, the largely rural northern and Sierra counties experienced a significant drop in employment-based insurance throughout

EXHIBIT 12. FAMILY CITIZENSHIP AND IMMIGRATION STATUS BY HEALTH INSURANCE COVERAGE DURING LAST 12 MONTHS, AGES 0-17, CALIFORNIA, 2001 AND 2003

	UNINSURED ALL YEAR		UNINSURED PART YEAR		EMPLOYMENT-BASED INSURANCE ALL YEAR		MEDI-CAL OR HEALTHY FAMILIES ALL YEAR		OTHER ALL YEAR		TOTAL
CITIZENSHIP AND IMMIGRATION STATUS	**2003**	**CHANGE FROM 2001[i]**	**2003**	**CHANGE FROM 2001**	**2003**	**CHANGE FROM 2001**	**2003**	**CHANGE FROM 2001**	**2003**	**CHANGE FROM 2001**	**2003**
BOTH PARENTS U.S.-BORN CITIZENS	1.7	-0.6**	4.8	-0.8	65.4	-4.9**	18.6	+3.2**	9.6	+3.1**	100% 4,708,000
PARENT NATURALIZED CITIZEN	3.0	-2.6**	5.3	-1.7*	57.5	-0.8	26.9	+2.7*	7.3	+2.4**	100% 2,189,000
PARENT NONCITIZEN WITH GREEN CARD	6.5	-6.3**	7.0	-1.3	33.1	+0.2	46.5	+5.6**	6.9	+1.8	100% 1,257,000
PARENT NONCITIZEN WITHOUT GREEN CARD	2.6	-7.5**	8.1	-3.4	11.9	-2.8	73.1	+12.3**	4.3	+1.3	100% 675,000
CHILD NONCITIZEN, AGES 0-17	28.3	-6.1*	9.1	-1.8	17.4	-5.9**	37.3	+11.9**	8.0	+1.9	100% 659,000

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

i Change in percentage points, not in the percent of the total estimate. Change is from reweighted 2001 California Health Interview Survey.

* Change is statistically significant at $p < 0.1$.

** Change is statistically significant at $p < 0.05$.

Source: 2001-R and 2003 California Health Interview Surveys

EXHIBIT 13. COUNTY AND REGION BY HEALTH INSURANCE COVERAGE DURING LAST 12 MONTHS, AGES 0-64, CALIFORNIA, 2003

	UNINSURED ALL OR PART YEAR		EMPLOYER-BASED INSURANCE ALL YEAR		MEDI-CAL OR HEALTHY FAMILIES ALL YEAR		OTHER ALL YEAR		TOTAL POPULATION AGES 0-64
	2003 %	CHANGE FROM 2001[i]	2003 %	CHANGE FROM 2001	2003 %	CHANGE FROM 2001	2003 %	CHANGE FROM 2001	2003
NORTHERN & SIERRA COUNTIES	22.8	NS	46.5	-5.0	20.1	+3.9	10.6	NS	1,110,000
BUTTE	20.6	NS	44.2	—	22.9	+	12.3	NS	174,000
SHASTA	23.2	NS	50.8	NS	19.8	NS	6.2	—	143,000
HUMBOLDT, DEL NORTE	24.3	NS	44.5	—	20.6	NS	10.6	NS	130,000
SISKIYOU, LASSEN, TRINITY, MODOC	18.7	NS	49.3	NS	21.3	NS	10.6	NS	76,000
MENDOCINO, LAKE	23.2	NS	44.7	NS	20.2	NS	12.0	NS	125,000
TEHAMA, GLENN, COLUSA	25.6	NS	41.0	NS	24.4	NS	9.0	NS	88,000
SUTTER, YUBA	21.5	NS	47.5	NS	23.6	NS	7.4	NS	129,000
NEVADA, PLUMAS, SIERRA	25.1	+	46.8	—	11.9	NS	16.2	NS	100,000
TUOLUMNE, INYO, CALAVERAS, AMADOR, MARIPOSA, MONO, ALPINE	23.2	NS	49.0	—	16.3	+	11.5	NS	145,000
GREATER BAY AREA	15.2	NS	63.8	-4.4	9.6	+1.0	11.4	+2.5	6,084,000
SANTA CLARA	14.3	NS	64.3	—	10.4	NS	10.9	+	1,525,000
ALAMEDA	17.9	+	61.7	—	10.9	NS	9.5	+	1,323,000
CONTRA COSTA	12.6	NS	67.9	NS	9.6	NS	9.9	NS	885,000
SAN FRANCISCO	18.1	NS	60.4	NS	8.7	NS	12.8	NS	663,000
SAN MATEO	16.7	+	64.8	NS	6.2	NS	12.3	NS	617,000
SONOMA	16.4	NS	60.1	—	8.5	+	14.9	NS	404,000
SOLANO	9.8	NS	68.8	NS	11.8	NS	9.8	+	355,000
MARIN	9.0	NS	64.9	NS	5.0	NS	21.1	NS	205,000
NAPA	17.0	NS	62.4	NS	9.4	NS	11.2	NS	107,000
SACRAMENTO AREA	15.3	NS	61.5	-5.6	13.6	+4.1	9.6	+2.5	1,716,000
SACRAMENTO	15.9	NS	58.2	—	17.0	+	8.9	+	1,166,000
PLACER	11.4	NS	70.5	—	4.6	NS	13.5	+	244,000
YOLO	14.9	NS	68.2	NS	7.4	NS	9.4	NS	160,000
EL DORADO	17.3	NS	65.8	NS	8.0	NS	9.0	NS	146,000

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EXHIBIT 13. COUNTY AND REGION BY HEALTH INSURANCE COVERAGE DURING LAST 12 MONTHS, AGES 0-64, CALIFORNIA, 2003 (CONT.)

	UNINSURED ALL OR PART YEAR		EMPLOYER-BASED INSURANCE ALL YEAR		MEDI-CAL OR HEALTHY FAMILIES ALL YEAR		OTHER ALL YEAR		TOTAL POPULATION AGES 0-64
	2003 %	CHANGE FROM 2001[i]	2003 %	CHANGE FROM 2001	2003 %	CHANGE FROM 2001	2003 %	CHANGE FROM 2001	2003
SAN JOAQUIN VALLEY	23.1	NS	47.0	-2.2	22.5	+1.9	7.4	NS	3,145,000
FRESNO	24.3	NS	46.4	NS	23.6	NS	5.7	NS	757,000
KERN	24.7	NS	44.0	NS	25.0	+	6.3	NS	619,000
SAN JOAQUIN	20.0	NS	55.0	NS	14.5	NS	10.5	+	552,000
STANISLAUS	21.0	NS	52.0	—	16.7	NS	10.3	NS	433,000
TULARE	24.4	—	40.0	NS	30.5	+	5.1	NS	352,000
MERCED	25.8	NS	40.1	—	27.6	+	6.5	NS	208,000
KINGS	17.8	—	46.6	NS	26.8	+	8.8	NS	113,000
MADERA	24.6	NS	44.1	NS	24.0	NS	7.3	NS	110,000
CENTRAL COAST	20.0	-3.6	54.7	NS	13.5	+2.9	11.9	+2.5	1,888,000
VENTURA	17.6	—	59.3	NS	12.1	NS	11.0	NS	702,000
SANTA BARBARA	21.1	—	51.6	NS	14.3	NS	13.0	+	345,000
SANTA CRUZ	18.7	NS	53.5	NS	13.6	NS	14.1	+	226,000
SAN LUIS OBISPO	19.2	NS	51.8	NS	15.6	+	13.5	NS	202,000
MONTEREY,	24.3	NS	51.3	—	14.1	NS	10.3	+	414,000
LOS ANGELES	23.7	-2.8	49.5	NS	18.4	+1.5	8.5	+1.5	8,826,000
LOS ANGELES	23.7	—	49.5	NS	18.4	+	8.5	+	8,826,000
OTHER SOUTHERN CALIFORNIA	22.8	NS	52.7	-3.2	14.4	+1.5	10.1	+1.7	2,627,000
ORANGE	22.6	NS	55.5	—	12.2	+	9.7	NS	2,667,000
SAN DIEGO	21.9	NS	54.7	—	11.9	NS	11.6	+	2,581,000
SAN BERNARDINO	22.7	NS	47.7	—	20.7	NS	8.9	NS	1,671,000
RIVERSIDE	24.8	NS	51.1	NS	14.4	NS	9.6	NS	1,496,000
IMPERIAL	25.3	NS	36.7	NS	29.0	NS	9.0	+	132,000

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

i Change in percentage points, not in the percent of the total estimate. Change is from reweighted 2001 California Health Interview Survey.

+ = Positive change from 2001 to 2003, and change is statistically significant at $p < 0.1$.

— = Negative change from 2001 to 2003, and change is statistically significant at $p < 0.1$.

NS = No statistically significant change from 2001 to 2003.

Source: 2001-R and 2003 California Health Interview Surveys

the year (down five percentage points), but all-year coverage in Medi-Cal and Healthy Families increased 3.9 percentage points to offset most of the loss in job-based coverage.

The urban and suburban San Francisco Bay Area saw employment-based insurance fall more than four percentage points, but this was mostly offset by a small increase in Medi-Cal and Healthy Families and a larger increase in other coverage, including county-sponsored children's health insurance programs and privately purchased health insurance. Within the Bay Area, Santa Clara, Alameda and Sonoma Counties experienced a significant decline in job-based insurance coverage, but all three also saw significant increases in a combination of other coverages, including county-sponsored children's health insurance and privately purchased coverage.

The Sacramento area, and Sacramento County in particular, experienced a 5.6 percentage-point drop in job-based insurance, but this was offset by an increase in Medi-Cal/Healthy Families coverage and an increase in privately purchased coverage. The predominantly rural San Joaquin Valley also experienced a drop in job-based insurance, largely offset by increased enrollment in Medi-Cal/Healthy Families. The Central Coast experienced a decrease in uninsurance, driven by a significant rise in enrollment in Medi-Cal and Healthy Families, as well as in privately purchased health insurance.

Los Angeles County, home to nearly a third of the state's population, saw no change in employment-based health insurance, but it experienced significant increases in Medi-Cal and Healthy Families, and in privately purchased health insurance.

Other southern California counties, which together nearly equal Los Angeles County's share of the state's population, experienced significant losses in employment-based insurance. Several individual counties in this group—Orange, San Diego and San Bernardino Counties—showed significant losses in job-based insurance. The region's loss in job-based insurance was matched by significant increases in enrollment in Medi-Cal and Healthy Families, as well as in privately purchased insurance.

2. EMPLOYMENT-BASED INSURANCE COVERAGE

2

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EMPLOYMENT-BASED COVERAGE OF DEPENDENTS FELL IN 2003

Job-based coverage is the foundation of California's health insurance system, albeit a crumbling one. A majority of nonelderly adults get their coverage through their own or a family member's employment, but the decline in employment-based health insurance in 2003 suggests that the long-term erosion of this foundation continues unabated. It is therefore noteworthy that *the decline of job-based coverage among adults in 2003 occurred entirely among those who had coverage through a family member's employment (dependent coverage), and that the proportion of adults who received health insurance through their own employer (primary coverage) remained stable.* In this section, we examine these changes, which paradoxically, seem to result more from the squeeze of shrinking employment opportunities than from a strengthening of job-based insurance.

In 2003, 14.5% of all nonelderly adults had employment-based health insurance throughout the year through their spouse or other family member, down 2.2 percentage points from 2001 (Exhibit 14). Another 40% had all-year coverage through their own job in 2003, which reflected a small (not statistically significant) increase from 2001. Just over 2% of adults had employment-based insurance for part of the year and some other coverage for the balance of the year, up slightly from 2001. The percent that had job-based insurance part of the year and were uninsured for the rest of the year (4.8%) was down slightly from 2001. Finally, 8.4% of adults

EXHIBIT 14. INSURANCE STATUS AMONG ALL ADULTS, AGES 18-64, CALIFORNIA, 2001 AND 2003

INSURANCE STATUS	PERCENT IN 2003	CHANGE FROM 2001[i]
JOB-BASED COVERAGE ALL YEAR – OWN COVERAGE	40.0	+0.6
JOB-BASED COVERAGE ALL YEAR – COVERAGE THROUGH SPOUSE	14.5	-2.2**
JOB-BASED COVERAGE PART YEAR AND OTHER INSURANCE	2.1	+0.2*
JOB-BASED COVERAGE PART YEAR AND UNINSURED	4.8	-0.5**
PRIVATELY PURCHASED COVERAGE ALL YEAR	5.9	+0.1
MEDI-CAL ALL YEAR	9.5	+0.4
UNINSURED ALL YEAR	15.0	0.0
OTHER OR COMBINATION OF COVERAGES ALL YEAR	8.4	+1.4**
TOTAL ADULT POPULATION	100.0% 21,828,000	N/A

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

i Change in percentage points, not in the percent of the total estimate. Change is from reweighted 2001 California Health Interview Survey.

* Change is statistically significant at $p < 0.1$.

** Change is statistically significant at $p < 0.05$.

Source: 2001-R and 2003 California Health Interview Surveys

had coverage throughout the year through some combination of insurance types, a churning process that affected more people in 2003 than in 2001.

It is clear that a smaller proportion of adults had coverage all year through a spouse in 2003 than in 2001, while an even smaller proportion gained year-round coverage in their own name. What we cannot tell from the data is whether individuals who in 2001 had dependent coverage through a spouse simply lost it by 2003, or whether they obtained coverage through their own employer or some other source. Because CHIS is a "cross-sectional survey" (that is, a different sample of people is interviewed in each cycle), we cannot distinguish what changes are occurring for individuals. In order to assess what actually happened to individuals, we would need to track them from one cycle to the next through a "panel" or "longitudinal" survey.

The decline in employment-based insurance occurred entirely among adults who had dependent coverage through a family member's employment.

Employment-based coverage for individual workers remained unchanged between 2001 and 2003, but employment-based coverage for a dependent declined sharply. These findings for adults parallel the data presented for children in the Overview section (Chapter 1), where we found that children's all-year employment-based insurance declined even more sharply.[8]

This decline in dependent coverage is understandable when we take account of soaring premium costs for family coverage. This was the result of two compounded changes: the large increase in the cost of coverage; and the dramatic increase in the share of the premiums that employers required their workers to pay in 2003 than in 2001. As noted in the previous chapter, between 2001 and 2003 the average total cost of worker-only coverage in California rose 31.6% and the average for family coverage rose 36.1%. However, the required employee contribution for worker-only coverage rose an average of 65.2% while the contribution for family coverage shot up 79.1% during this period.[9] In 2003 the average worker contributed $2,452 for family coverage, nearly six times the required contribution for worker-only coverage.[10] Of course, many workers, especially those at the lower end of the state's economic hierarchy, pay more than that because employers are, in general, more generous in subsidizing the coverage of higher-wage workers than lower-wage workers.

During this period, as the cost of coverage rose, real per capita income in California declined by 1.6%, from $32,190 to $31,659,[11] decreasing the purchasing power of the average California family. In addition, as the population and the

8 Data from the California sample of the 2002 and 2004 Current Population Surveys (CPS) show a different trend, namely that primary coverage decreased. Please see the Appendix for a complete discussion of the differences between CPS and the California Health Interview Survey (CHIS) used for this report.

9 Kaiser Family Foundation and the Health Research and Educational Trust, *California Employer Health Benefits Survey, 2003*, Menlo Park, CA: Henry J. Kaiser Family Foundation, March 2004, and *California Employer Health Benefits Survey 2004*, Oakland: California HealthCare Foundation and the Health Research and Educational Trust, 2004.

10 *California Employer Health Benefits Survey 2004.*

11 U.S. Department of Commerce, Bureau of Economic Analysis, *http://www.bea.doc.gov/*, accessed on 6/05/05.

labor force grew, the number of jobs fell, pushing up unemployment from an average of 5.4% in 2001 to 6.7% in 2003. Thus, one might assume that access to employment-based coverage declined since fewer Californians had jobs, a possible explanation that we will examine next.

EMPLOYEES MORE LIKELY TO HAVE ACCESS TO JOB-BASED INSURANCE AND MORE LIKELY TO ACCEPT IT IN 2003

The proportion of employees who worked for an employer that offered health benefits (called "the offer rate") rose 1.5 percentage points between 2001 and 2003, to 83.7% (Exhibit 15).[12] The offer rate could rise if more employers offer health benefits, although there is no evidence for this in 2003, based on surveys of employers.[13] The offer rate also could rise if more workers get jobs with employers that offer benefits. This too seems unlikely given the shrinking labor market. Between 2001 and 2003, California's population of adults aged 16-64 grew 3.2% (adding 709,000 to the 22.3 million in 2001), while the number of those adults in the labor force grew less than one percent (adding 118,000 to the 16.8 million

12 Employees are workers employed for wages or salary, excluding self-employed workers. Note that CHIS is a population survey and that, like other surveys of the population, the resulting offer rate reflects the *percent of employees who work for an employer* that offers coverage. This measure differs from offer rates calculated from surveys of employers; in such surveys, the analogous estimate is calculated from responses of employers about their firm and about the total number of employees in that firm.

13 Kaiser Family Foundation and the Health Research and Educational Trust, *California Employer Health Benefits Survey, 2003*.

EXHIBIT 15. OFFER, ELIGIBILITY AND TAKE-UP RATES AMONG EMPLOYEES, AGES 18-64, CALIFORNIA, 2001 AND 2003

	PERCENT OF EMPLOYEES WHOSE EMPLOYER *OFFERS* COVERAGE (OFFER RATE)[i]		PERCENT OF EMPLOYEES WHO ARE *ELIGIBLE* AMONG THOSE WHOSE EMPLOYER OFFERS COVERAGE (ELIGIBILITY RATE)[ii]		PERCENT OF EMPLOYEES WHO HAVE *ACCESS* TO EMPLOYMENT-BASED INSURANCE (ACCESS RATE)[iii]		PERCENT OF EMPLOYEES WHO *TAKE-UP* COVERAGE AMONG THOSE WHO ARE ELIGIBLE (TAKE-UP RATE)[iv]	
	2003	CHANGE FROM 2001[v]	2003	CHANGE FROM 2001	2003	CHANGE FROM 2001	2003	CHANGE FROM 2001
TOTAL POPULATION OF EMPLOYEES AGES 18-64 IN 2003 = 14,184,000	83.7%	+1.5**	89.4%	-0.9**	74.9%	+0.6	85.4%	+1.7**

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

i Offer rate = The total number of employees who work for employers that *offer* health insurance divided by the *total* number of employees.

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

iii Access rate = The total number of employees *who are offered and eligible* for their employer's plan divided by the *total* number of employees.

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

v Change in percentage points, not in the percent of the total estimate. Change is from reweighted 2001 California Health Interview Survey.

* Change is statistically significant at $p < 0.1$.

** Change is statistically significant at $p < 0.05$.

Source: 2001-R and 2003 California Health Interview Surveys

in 2001).[14] Thus, the labor force participation rate declined from 75.4% in 2001 to 73.6% in 2003. During this time, unemployment rose from 932,600 to 1,190,500, an increase of 28%.[15] A more likely explanation is that, as the economy declined, more jobs that did not provide health benefits were lost than the number of jobs that provided benefits, leaving a larger proportion of workers employed by an employer that offered health insurance.

Even as the offer rate rose, the percent of those who are eligible for their own employer's insurance plan ("the eligibility rate") fell by a nearly equal magnitude—down 0.9 percentage points to 89.4% of those whose employer offered health benefits. The eligibility rate can fall if fewer workers are employed the minimum number of hours required by their employer for eligibility, a factor that probably contributed to this change as the average number of hours worked per week declined with the shrinking economy. Based on analyses of the Current Population Survey, the proportion of employees that worked full-time for the full year declined between 2001 and 2004 in firms employing 500 or more workers, and the proportion that worked part-time increased. These are the larger firms that are most likely to offer health benefits, but the increase in part-time and part-year employment at these firms suggests that fewer of their employees would be eligible for health benefits.

In addition, the eligibility rate could fall if more workers have moved to new jobs and not worked the minimum period of time required by their employer. But the eligibility rate also could fall if employers change the rules to reduce the number of workers who are eligible for benefits. An example of the latter change is the settlement of the Southern California supermarket strike in early 2004. In that settlement, employers changed the eligibility rules for health benefits to require that new employees must work 12 months before becoming eligible and that they must work 30 months before their family dependents would be eligible for health insurance.[16]

We characterize workers as having *access* to job-based insurance if they work for an employer that *offers* employer health benefits *and* if they also are *eligible* for those benefits. In 2003, 74.9% of employees had access to job-based insurance, up just 0.6 percentage points from 2001.

Among employees with access to health benefits, 85% took up their employer's offer of coverage ("the take-up rate"), an increase of 1.7 percentage points in 2003—ironically, despite the rising cost of premiums for employees. Thus, in 2003 more workers gained jobs with employers that offered coverage, a smaller proportion of workers was eligible for health benefits, but more workers who were eligible accepted the benefits. At least part of the explanation for the increased take-up may be that as working spouses lost employment and some workers thereby lost dependent coverage, those who kept their jobs accepted the employer's offer of health benefits when it was available. That could occur even if the employer required higher employee cost-sharing—and could happen despite rising health insurance premiums—because

14 State of California, Department of Finance, *California Current Population Survey Report: March 2001 Data*, Sacramento, California, February 2002, and State of California, Department of Finance, *California Current Population Survey Basic Report: March 2003 Data*, Sacramento, California. December 2003.

15 Data from California Employment Development Department, *http://www.labormarketinfo.edd.ca.gov/ cgi/dataanalysis/ labForceReport.asp?menuchoice=LABFORCE*, accessed 6/05/05.

16 *Tentative Agreement for a Successor Collective Bargaining Agreement between Albertson's Inc., Ralphs Grocery Company and Vons, a Safeway Company, and United Food and Commercial Workers Locals 135, 324, 770, 1036, 1167, 1428 and 1442*, February 26, 2004.

the options for these working families had been reduced but their need for coverage had not.

FOR MOST GROUPS, OFFER AND TAKE-UP RATES ROSE AND ELIGIBILITY RATES FELL

The proportion of employees who were offered health benefits rose among most population groups between 2001 and 2003, although that increase was somewhat offset by declines in the proportion of employees who were eligible for health coverage. Take-up rates also rose among most groups of employees (Exhibit 16).

In 2003 the proportion of workers whose employers offered coverage increased, the proportion who were eligible for health benefits shrank, but more workers who were eligible accepted the benefits.

A larger proportion of men than women had access to job-based insurance, both of which were up slightly from 2001. This difference in access to benefits reflects the greater prevalence of part-time work among female workers. While 94% of employed men work full-time, only 84.7% of employed women have full-time jobs (data not shown). Men were also more likely to accept coverage in their own name, reflecting a longstanding pattern of women being more likely than men to be covered as dependents.

As age increases, so does access to and take up of coverage. Employees aged 18-24 had the lowest access among all age groups: 51.3%, up 1.1 percentage points in 2003. Take-up rates were also lowest for this age group, in part because some of them may be eligible for a parent's health benefits and, for many, young entry-level workers typically earn low wages and find premiums difficult to afford. Nevertheless, take-up rates among workers aged 18-24 increased by over six percentage points to 74.1% in 2003, the biggest increase of any age group.

Unsurprisingly, access rates were lowest among the poor as well as among those without a high school diploma, noncitizens and single parents, all of whom tend to have low wages and low family incomes. Nearly nine out of 10 employees (87.1%) with family incomes above 300% of the federal poverty level had access to job-based insurance, compared with only 39.3% of workers with incomes at or below poverty. While 88.1% of college graduates had access to health benefits on their jobs, this was true for only 53.4% of employees with less than a high school education. Unlike most workers, single parents with children experienced a statistically significant decline in access to health benefits, a drop that is particularly problematic because, unlike married couples, single parents have no opportunity to obtain employment-based coverage as a dependent. Workers with little education and those who are poor also had the lowest take-up rates, although the differences between groups in take-up rates were much smaller than the differences in access.

Racial and ethnic disparities persisted, with Latinos and American Indian/Alaska Natives having the poorest access to job-based insurance through their own employment. Eight out of 10 U.S.-citizen employees had access to job-based coverage, while only 64.4% of noncitizen green card holders and just 45.4% of those without green cards had access.

EXHIBIT 16. ACCESS AND TAKE-UP RATES AMONG EMPLOYEES BY DEMOGRAPHIC CHARACTERISTICS, AGES 18-64, CALIFORNIA, 2001 AND 2003

	PERCENT OF EMPLOYEES WHO HAVE ACCESS TO JOB-BASED COVERAGE (ACCESS RATE)[i]		PERCENT OF EMPLOYEES WHO TAKE-UP COVERAGE AMONG THOSE WHO ARE ELIGIBLE (TAKE-UP RATE)[ii]	
	2003	CHANGE FROM 2001[iii]	2003	CHANGE FROM 2001
EMPLOYEES, AGES 18-64	**74.9%**	**+0.6**	**85.4%**	**+1.7****
GENDER				
MALE	77.3%	+0.4	87.9%	+1.1
FEMALE	71.8%	+0.8	81.9%	+2.5**
AGE GROUP				
AGES 18-24	51.3%	+1.1	74.1%	+6.0**
AGES 25-34	73.0%	-1.2	84.7%	-0.9
AGES 35-44	78.7%	-0.2	86.7%	+2.2**
AGES 45-54	83.7%	+2.0**	87.0%	+1.5
AGES 55-64	85.7%	+3.2**	90.1%	+2.2*
FAMILY COMPOSITION				
SINGLE, NO CHILDREN	67.8%	-0.4	88.1%	+0.8
SINGLE, WITH CHILDREN	66.9%	-4.7**	88.0%	0.0
MARRIED, NO CHILDREN	85.7%	+3.0**	85.9%	+2.8**
MARRIED, WITH CHILDREN	77.3%	+1.2	82.1%	+2.2**
RACE/ETHNICITY				
WHITE	80.9%	+1.0	87.0%	+2.7**
LATINO	60.3%	+0.4	80.8%	-0.4
ASIAN AMERICAN AND PACIFIC ISLANDER	81.0%	+2.6	85.2%	+1.4
AFRICAN AMERICAN	81.6%	-0.9	87.2%	-0.2
AMERICAN INDIAN/ALASKA NATIVE	65.0%	-6.3	81.5%	+0.9
OTHER AND MULTIPLE RACE	72.8%	-2.7	87.3%	+5.4
CITIZENSHIP STATUS				
U.S.-BORN CITIZEN	79.0%	+0.2	86.3%	+2.0**
NATURALIZED CITIZEN	81.4%	+2.4*	86.0%	+2.4*
NONCITIZEN WITH GREEN CARD	64.4%	+1.2	81.9%	+1.5
NONCITIZEN WITHOUT GREEN CARD	45.4%	+1.8	76.2%	-5.2
EDUCATION LEVEL				
LESS THAN HIGH SCHOOL	53.4%	+2.2	79.3%	+0.5
HIGH SCHOOL DIPLOMA	68.5%	-1.6	81.5%	+0.7
SOME COLLEGE	76.4%	+0.5	84.9%	+2.3**
COLLEGE GRADUATE OR HIGHER	88.1%	+0.5	89.4%	+1.9**

continued on next page

EXHIBIT 16. ACCESS AND TAKE-UP RATES AMONG EMPLOYEES BY DEMOGRAPHIC CHARACTERISTICS, AGES 18-64, CALIFORNIA, 2001 AND 2003 (CONT.)

	PERCENT OF EMPLOYEES WHO HAVE ACCESS TO JOB-BASED COVERAGE (ACCESS RATE)[i]		PERCENT OF EMPLOYEES WHO TAKE-UP COVERAGE AMONG THOSE WHO ARE ELIGIBLE (TAKE-UP RATE)[ii]	
	2003	CHANGE FROM 2001[iii]	2003	CHANGE FROM 2001
INCOME AS PERCENT OF FEDERAL POVERTY LEVEL				
< 100%	39.3%	+4.4**	69.2%	+1.4
100 - 199%	57.2%	-2.7	78.9%	-1.0
200 - 299%	72.2%	-2.0	86.7%	+3.3**
300% +	87.1%	+1.1*	87.7%	+1.9**
WAGES PER HOUR LAST MONTH				
< $9.51	49.0%	+1.6	73.1%	+1.5
$9.51-$14.25	73.1%	-2.8*	83.2%	+0.9
$14.26-$19.00	86.2%	-0.4	86.9%	+0.5
$19.01+	91.4%	-0.5	90.2%	+1.6**
SELECTED INDUSTRIES				
AGRICULTURE	45.7%	N/A	87.5%	N/A
CONSTRUCTION	61.3%	N/A	82.5%	N/A
MANUFACTURING	79.4%	N/A	87.0%	N/A
PROFESSIONAL AND BUSINESS SERVICES	78.7%	N/A	86.1%	N/A
PUBLIC ADMINISTRATION	91.0%	N/A	89.5%	N/A
WHOLESALE AND RETAIL TRADE	71.4%	N/A	82.0%	N/A
HOURS WORKED PER WEEK				
0-20 HOURS	41.5%	+7.5**	75.0%	+17.5**
21-34 HOURS	50.3%	+1.3	70.3%	+4.2
35-39 HOURS	67.0%	-2.1	77.6%	+4.2
40+ HOURS	82.2%	+0.4	87.3%	+0.6
FIRM SIZE				
FEWER THAN 10 EMPLOYEES	48.8%	+14.1**	84.3%	+11.7**
10-50 EMPLOYEES	60.2%	-2.5	80.2%	+1.9
51-99 EMPLOYEES	73.8%	-2.5	82.9%	+2.0
100-999 EMPLOYEES	81.1%	-1.4	83.2%	-3.0**
1000+ EMPLOYEES	87.1%	-3.3**	87.2%	+0.7

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

i Access rate = The total number of employees *who were offered and eligible* for their employer's plan divided by the *total* number of employees.

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

iii Change in percentage points, not in the percent of the total estimate. Change is from reweighted 2001 California Health Interview Survey.

N/A = Not applicable. Change from 2001 cannot be reported because the variable categories changed dramatically in the variable construction.

* Change is statistically significant at $p < 0.1$.

** Change is statistically significant at $p < 0.05$.

Source: 2001-R and 2003 California Health Interview Surveys

EXHIBIT 17. OTHER ACCESS TO EMPLOYER-BASED INSURANCE AMONG EMPLOYEES THAT DO NOT HAVE ACCESS TO THEIR OWN EMPLOYER-BASED INSURANCE, AGES 18-64, CALIFORNIA, 2003	
	EMPLOYEES WITH NO ACCESS TO EMPLOYER-BASED INSURANCE
HAS EMPLOYER-BASED INSURANCE THROUGH A FAMILY MEMBER	**19.8% 705,000**
DOES NOT HAVE EMPLOYER-BASED INSURANCE THROUGH A FAMILY MEMBER	**80.3% 2,858,000**
HAS SPOUSE WITH ACCESS TO EMPLOYER-BASED INSURANCE	5.8% 206,000
HAS SPOUSE WITH NO ACCESS TO EMPLOYER BASED INSURANCE	60.7% 2,161,000
DOES NOT HAVE SPOUSE	13.8% 492,000
TOTAL POPULATION IN 2003	**100% 3,563,000**

Note: Numbers may not add to 100% due to rounding.
Source: 2003 California Health Interview Survey

Only half of workers in low-wage jobs (paying less than $9.51 per hour) had access to employment-based insurance coverage, compared to nine out of 10 employees earning more than $19 per hour.

Offer, eligibility and take-up rates remain constant overall, but some vulnerable groups lost eligibility.

Lastly, employees who work for small firms and employees who work part-time continued to have very low rates of access to job-based insurance through their employer, but both groups saw significant gains. The offer rate among firms with less than 10 employees jumped 14 percentage points to 56%, while the offer rates for employees who worked in mid-size and large firms fell. Part-time workers employed less than 21 hours per week saw their offer rates jump six percentage points to 68%.

EMPLOYEES WITHOUT ACCESS TO THEIR OWN JOB-BASED INSURANCE

A total of 3.6 million California employees did not have access to health insurance through their own job in 2003 (Exhibit 17). Only about one in five of them (19.8%) obtained coverage through another family member's employment-based insurance in 2003. Only a small fraction of those who did not have any employment-based coverage had a spouse with such access through his or her own job: 206,000, or 5.8%.[17] More than 2.1 million had a spouse who also did not have any access to job-based insurance, and another 492,000 were not married.

17 Questions about a spouse's coverage were asked beginning in CHIS 2003 and are thus not available for 2001.

UNINSURED EMPLOYEES

Among employees who were uninsured at the time of the CHIS interview in 2003, 57.2% worked for a firm that did not offer health insurance to their employees at all, a smaller proportion than in 2001 (Exhibit 18). One-fourth of uninsured employees (25.1%) worked for firms that offered insurance for which they were not eligible. Altogether, 83.3% of uninsured employees simply did not have access to employment-based health insurance through their own jobs. Finally, 17.7% did not take up health insurance coverage for which they were eligible, also higher than in 2001 in response to rising health insurance premiums.

3.6 million California employees did not have access to health insurance through their own jobs in 2003.

83.3% of uninsured employees did not have access to employment-based health insurance through their own jobs.

It is not surprising that the most economically vulnerable uninsured employees are the most likely to work for firms that do not offer health insurance to any employee, but a number of groups that are not as vulnerable also face this barrier to getting employment-based health insurance. Among uninsured employees, 63.7% of Latinos, and more than half of Asian American and Pacific Islanders and American Indian/Alaska Natives work for employers that do not offer health benefits. Seven in 10 uninsured noncitizens without green cards work for non-offering employers, as do more than six in 10 noncitizens with green cards and even naturalized citizens. The same is true for nearly seven in 10 uninsured workers with less than a high school education, and nearly six in 10 uninsured very low wage employees. It is also true for eight in 10 employees of firms with fewer than 10 workers and more than six in 10 firms with 10-50 employees. More than eight in 10 uninsured agricultural workers—as well as more than seven in 10 employed in construction and even six in 10 in manufacturing—work for employers that do not offer health benefits.

The proportion of uninsured employees who were eligible for health benefits from their employer but did not take them up is much lower than the proportions of those who either worked for an employer that did not offer them or were not eligible for them. But as with lacking eligibility, higher proportions of the more advantaged uninsured workers did not accept their employer's plan. Thus, the very groups that often are assumed not to value health insurance are the very groups that, in fact, are most likely to be uninsured because they worked for employers that did not offer health benefits, and were among the least likely not to accept health benefits when they were eligible.

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

Some California employees choose not to participate in their employer's health plan, even though they are eligible. To better understand why—whether their failure to take up health insurance is due to prohibitive cost, personal values, or having more than one coverage option—we examined the reasons eligible employees reported for not taking up employer-sponsored coverage by grouping all eligible employees together, as well as looking separately at eligible uninsured employees.

EXHIBIT 18. SELECTED DEMOGRAPHICS AND LABOR MARKET CHARACTERISTICS BY ACCESS TO OWN JOB-BASED INSURANCE AMONG UNINSURED EMPLOYEES,[i] AGES 18-64, CALIFORNIA, 2001 AND 2003

	NOT OFFERED		NOT ELIGIBLE		DID NOT ACCEPT		TOTAL POPULATION
	2003 %	CHANGE FROM 2001[ii]	2003 %	CHANGE FROM 2001	2003 %	CHANGE FROM 2001	2003
EMPLOYEES, AGES 18-64	57.2	-5.0**	25.1	+2.0	17.7	+2.9**	2,150,000
RACE/ETHNICITY							
WHITE	48.4	+1.9	36.1	-1.3	15.5	-0.5	567,000
LATINO	63.7	-7.9**	19.9	+5.6**	16.5	+2.3	1,227,000
ASIAN AMERICAN AND	52.7	-6.3	18.8	-5.6	28.4	+11.9**	168,000
AFRICAN AMERICAN	42.0	-8.0	26.6	-7.9	31.3	+15.9**	93,000
AMERICAN INDIAN/	55.3	-8.8	26.4	-0.1	18.3	+8.9	37,000
OTHER AND MULTIPLE RACE	44.1	-19.6*	42.6	+17.0	13.3	+2.5	58,000
CITIZENSHIP STATUS							
U.S.-BORN CITIZEN	43.8	-2.4	37.7	-0.3	18.5	+2.6	921,000
NATURALIZED CITIZEN	61.2	-1.6	18.0	+0.3	20.8	+1.3	195,000
NONCITIZEN WITH GREEN CARD	65.5	-2.1	15.6	-0.4	18.9	+2.5	384,000
NONCITIZEN WITHOUT	69.9	-13.4**	15.0	+7.8**	15.2	+5.6**	650,000
EDUCATION LEVEL							
LESS THAN HIGH SCHOOL	69.2	-6.3**	14.9	+3.4	15.9	+2.9	894,000
HIGH SCHOOL DIPLOMA	52.6	-2.3	29.0	+0.4	18.4	+1.9	584,000
SOME COLLEGE	46.3	-7.4*	36.2	+5.6	17.5	+1.8	418,000
COLLEGE GRADUATE	43.2	-3.9	33.8	-3.8	23.0	+7.7**	255,000

EXHIBIT 18. SELECTED DEMOGRAPHICS AND LABOR MARKET CHARACTERISTICS BY ACCESS TO OWN JOB-BASED INSURANCE AMONG UNINSURED EMPLOYEES,[i] AGES 18-64, CALIFORNIA, 2001 AND 2003 (CONT.)

	NOT OFFERED		NOT ELIGIBLE		DID NOT ACCEPT		TOTAL POPULATION
	2003 %	CHANGE FROM 2001[ii]	2003 %	CHANGE FROM 2001	2003 %	CHANGE FROM 2001	2003
WAGES PER HOUR LAST MONTH							
< $9.51	59.3	-6.7**	24.2	+3.0	16.5	+3.7**	1,451,000
$9.51-$14.25	56.7	+3.3	26.0	-0.7	17.3	-2.5	354,000
$14.26-$19.00	43.8	-11.0	33.7	+7.2	22.6	+3.8	166,000
$19.01+	53.5	+9.8	22.5	-15.1**	24.0	+5.3	180,000
SELECTED INDUSTRIES							
AGRICULTURE	84.0	N/A	10.3	N/A	5.7	N/A	96,000
CONSTRUCTION	72.7	N/A	16.0	N/A	11.3	N/A	301,000
MANUFACTURING	59.8	N/A	19.8	N/A	20.5	N/A	254,000
PROFESSIONAL AND BUSINESS SERVICES	53.8	N/A	25.2	N/A	20.9	N/A	241,000
PUBLIC ADMINISTRATION	36.7	N/A	36.9	N/A	26.4	N/A	24,000
WHOLESALE AND RETAIL TRADE	52.0	N/A	32.9	N/A	15.1	N/A	252,000
FIRM SIZE							
FEWER THAN 10 EMPLOYEES	79.5	-4.0	14.8	+5.4**	5.8	-1.4	599,000
10-50 EMPLOYEES	65.4	-5.0	20.7	+5.6**	13.9	-0.5	664,000
51-99 EMPLOYEES	55.1	+0.3	22.2	-0.9	22.8	+0.6	113,000
100-999 EMPLOYEES	39.2	-8.6	28.9	-5.0	31.9	+13.6**	363,000
1000+ EMPLOYEES	28.8	+14.3**	44.5	-12.7**	26.7	-1.6	269,000

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

N/A = Not applicable. Change from 2001 cannot be reported since the variable categories changed dramatically in the variable construction.

i No insurance at time of CHIS interview.

ii Change in percentage points, not in the percent of the total estimate. Change is from reweighted 2001 California Health Interview Survey.

* Change is statistically significant at $p < 0.1$.

** Change is statistically significant at $p < 0.05$.

Source: 2001-R and 2003 California Health Interview Surveys

EXHIBIT 19. REASONS ELIGIBLE EMPLOYEES DO NOT PARTICIPATE IN EMPLOYER HEALTH PLANS BY INSURANCE STATUS AT TIME OF INTERVIEW, AGES 18-64, CALIFORNIA, 2001 AND 2003

	INSURED AT TIME OF CHIS 2003 INTERVIEW		UNINSURED AT TIME OF CHIS 2003 INTERVIEW	
SELF-REPORTED REASONS FOR NOT TAKING UP PLAN OFFERED BY OWN EMPLOYER	**2003**	**CHANGE FROM 2001[i]**	**2003**	**CHANGE FROM 2001**
COVERED BY ANOTHER PLAN/ COVERED BY SAME PLAN AS SPOUSE	66.3	-13.8**	13.1[ii]	+0.6
TOO EXPENSIVE	19.8	+6.9**	45.3	-7.4
TRADED INSURANCE FOR HIGHER PAY/ DOESN'T LIKE OR WANT COMPANY INSURANCE	7.3	+3.9**	5.2	-2.0
DON'T NEED/BELIEVE IN HEALTH INSURANCE	2.1	+0.3	14.7	+0.9
OTHER	4.5	+2.8**	21.7	+7.9**
TOTAL	100%	–	100%	–

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

i Change in percentage points, not in the percent of the total estimate. Change is from reweighted 2001 California Health Interview Survey.

ii These employees were covered by another plan at the time they had an offer for their own job-based insurance, but were uninsured by the time that they were interviewed.

* Change is statistically significant at $p < 0.1$.

** Change is statistically significant at $p < 0.05$.

Source: 2001-R and 2003 California Health Interview Surveys

Two-thirds of eligible *insured* employees who did not take up coverage said they were covered by another plan, usually that of their spouse (Exhibit 19). Among *uninsured* employees who were eligible for their employer's plan, the largest proportion (45.3%) reported they did not take up coverage because they could not afford the cost of the health benefits. This is not surprising given that the share of health premiums paid by workers continued to rise dramatically in 2003. About 5% of eligible uninsured employees reported not taking up coverage because they opted to trade health insurance for higher pay or they didn't like or want the company insurance. Among low- and even moderate-wage earners who struggle to purchase other necessities, foregoing health insurance in exchange for more money may be a rational choice made to satisfy more immediate and pressing needs for food and shelter, for example. However, allowing employees to opt out of health insurance in exchange for cash can have a negative effect on the risk pool. By leaving a higher concentration of sick people with more expensive care, and fewer people to shoulder the burden, it drives up the cost of premiums as healthier people tend to opt out of coverage.

Among uninsured employees who were eligible for their employer's plan, 45.3% reported they did not take up coverage because they could not afford the cost of the health benefits.

Some have speculated that a significant number of employees are voluntarily uninsured because they simply don't value coverage. However, only 14.7% of eligible uninsured employees reported that they did not take up their employer's coverage because they did not need or want health insurance. These findings suggest that while some Californians may not want health insurance coverage or may not value it sufficiently relative to other needs, this group is a small minority of uninsured employees. By far the number one reason among uninsured workers for declining coverage was affordability.

3. GROWTH IN MEDI-CAL AND HEALTHY FAMILIES FROM 2001 TO 2003

While job-based coverage for children declined from 2001 to 2003, the Medi-Cal and Healthy Families programs have both experienced significant growth. In fact, the percentage of children ages 0-18 who were continuously insured by these two programs rose a full 5.1 percentage points. There was also a corresponding decline in both the number and the percentage of uninsured children who were eligible for these programs but not enrolled. The number of children uninsured but eligible for either Medi-Cal or Healthy Families in 2003 dropped to 429,000 from 645,000 in 2001.

While these enrollment and retention successes should be celebrated, it is important to understand the factors associated with these successes to effectively extend coverage to all uninsured children. This section divides the discussion into two parts. The first is an explanation of the family situations of children who were currently enrolled in Medi-Cal or Healthy Families at the time of their CHIS 2003 interview. The second discusses the people who were uninsured at the time of the interview but eligible for one of these programs.

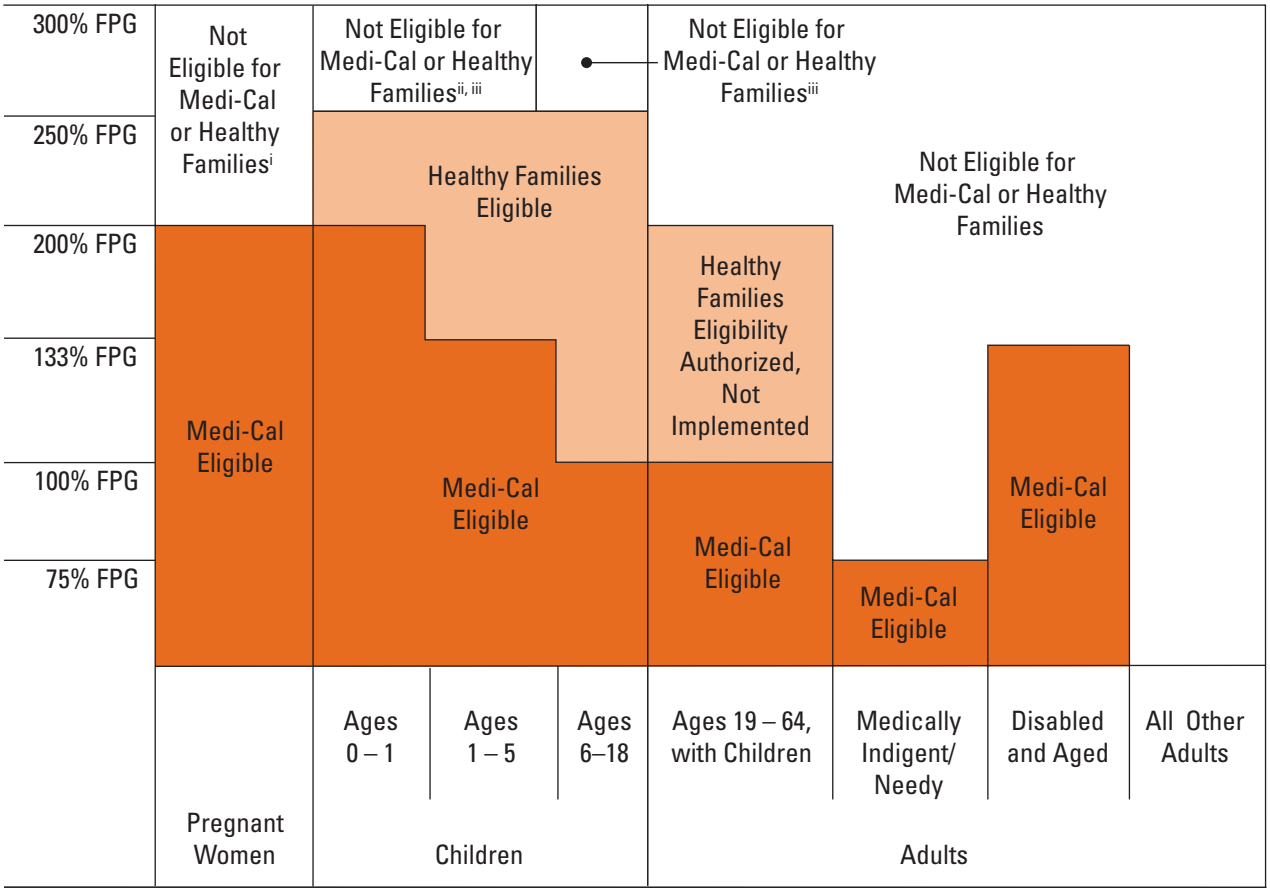
THE PATCHWORK QUILT REMAINS

Exhibit 20 details "the patchwork quilt" of eligibility requirements for public programs in California. This is a simplification of the over 150 eligibility categories into which Medi-Cal and Healthy Families applicants could possibly be placed. While pregnant women and children have numerous options for coverage (although by no means do existing public programs constitute universal access to health insurance for these populations), other adults have very limited access to public insurance. These differences in eligibility explain the large success of Healthy Families and Medi-Cal in preventing an increase in uninsurance among children who lost job-based coverage, but most adults did not share this protection.

One aspect of eligibility for Medi-Cal and Healthy Families is not noted in Exhibit 20 for either adults or children: immigration status. Noncitizens without green cards are ineligible for either "full-scope" Medi-Cal or Healthy Families, regardless of age or household income. They *are* eligible, however, for programs such as Emergency Medi-Cal and the Child Health and Disability Prevention program (CHDP); the latter covers preventive screening visits and follow-up care for children.

Between 2001 and the CHIS survey in 2003, seven county-based, public insurance programs began enrolling children in what most called "Healthy Kids" programs. Funded through locally-based public-private partnerships, the Healthy Kids programs provided an overlay of insurance intended to move these counties towards covering all children up to household incomes of 300% FPL, regardless of immigration status. Therefore, while Exhibit 20 notes that children with incomes too high for Healthy Families might be eligible for a local Healthy Kids initiative plan, Healthy Kids actually covers children all the way down the income scale who are otherwise ineligible for Medi-Cal or Healthy Families.

EXHIBIT 20. MEDI-CAL AND HEALTHY FAMILIES INCOME ELIGIBILITY AS A PERCENT OF FEDERAL POVERTY GUIDELINES (FPG) FOR FAMILIES WITH CHILDREN AND FOR PREGNANT WOMEN, ALL AGES, CALIFORNIA, 2003



FPG = Federal Poverty Guidelines

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

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

ii Children up to two years old with household incomes under 300% FPL with mothers in the AIM program may also be enrolled in the AIM program. California's state fiscal year 2004 budget calls for moving children currently enrolled in AIM but eligible for Healthy Families into the Healthy Families program.

iii Some counties may have county-based public-private partnership programs (most often called "Healthy Kids") that insure children through age 18 up to 300% FPL, regardless of immigration status.

These new health insurance programs add more options to move California closer to universal coverage for children. However, they also create additional layers of complexity—more squares in the patchwork quilt. Additionally, these programs exist because of generous local support, which likely cannot be sustained over the long-term. They remain a strong step forward, but they face major and possibly grave funding challenges without State or Federal support.

Exhibit 21 compares the insurance status and types of coverage that children ages 0-18 have had in the past 12 months across major racial and ethnic groups. This exhibit provides the overall backdrop for the rest of the discussion, which will focus on current Medi-Cal and Healthy Families enrollees and currently uninsured children who are eligible for either of these programs.

Latino and African-American children have greater proportions enrolled in Medi-Cal (37.7% and 33.9%, respectively) than whites (11.5%), and lower rates of job-based coverage (Exhibit 21). These groups also have higher proportions who were uninsured all or part of the year compared to whites.

MEDI-CAL AND HEALTHY FAMILIES ENROLLEES

While Medi-Cal is an established program without much change in enrollment patterns from 2001 to 2003, Healthy Families is still a relatively young program that changed patterns dramatically over that same time period. Fully 91.7% of children who were enrolled in Medi-Cal at the time of their CHIS interview (which we refer to as "current" enrollees) were in the program for the entire past year in 2003, which was not significantly different than the

EXHIBIT 21. INSURANCE COVERAGE OVER PAST 12 MONTHS BY RACE AND ETHNIC GROUP, AGES 0-18, CALIFORNIA, 2003

	WHITE	LATINO	ASIAN AMERICAN AND PACIFIC ISLANDER	AFRICAN AMERICAN	OTHER AND MULTIPLE RACE	TOTAL
MEDI-CAL ALL YEAR	**11.5**	**37.7**	**16.2**	**33.9**	**21.5**	**24.0**
HEALTHY FAMILIES ALL YEAR	**2.6**	**8.4**	**5.5**	**3.5**	**5.5**	**5.3**
JOB-BASED INSURANCE ALL YEAR	**68.4**	**30.3**	**59.7**	**47.2**	**50.7**	**50.8**
OTHER INSURANCE ALL YEAR[i]	**11.5**	**5.8**	**9.6**	**5.4**	**10.6**	**8.7**
UNINSURED AT ANY TIME	**6.0**	**17.7**	**9.0**	**10.0**	**11.7**	**11.2**
UNINSURED ALL YEAR	1.8	8.8	5.2	3.4	***	5.0
UNINSURED PART YEAR	4.2	9.0	3.9	6.6	6.3	6.2
POPULATION IN 2003	**100% 4,013,000**	**100% 3,745,000**	**100% 1,066,000**	**100% 806,000**	**100% 421,000**	**100% 10,051,000**

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

i "Other Insurance All Year" includes privately purchased insurance as well as other government programs and any type of insurance combination over the course of the past year.

*** = Estimate is unstable because coefficient of variation is over 30%.

Source: 2003 California Health Interview Survey

EXHIBIT 22. INSURANCE COVERAGE OVER PAST 12 MONTHS AMONG CURRENT MEDI-CAL AND HEALTHY FAMILIES ENROLLEES, AGES 0-18, CALIFORNIA, 2001 AND 2003

	ENROLLED IN MEDI-CAL AT THE TIME OF CHIS INTERVIEW		ENROLLED IN HEALTHY FAMILIES AT THE TIME OF CHIS INTERVIEW	
	2003 (POPULATION)	CHANGE FROM 2001[i]	2003 (POPULATION)	CHANGE FROM 2001
MEDI-CAL ALL YEAR	91.7 (2,408,000)	NS	N/A	N/A
HEALTHY FAMILIES ALL YEAR	N/A	N/A	86.8 (531,000)	+**
OTHER INSURANCE PART YEAR, NEVER UNINSURED	2.3 (61,000)	NS	6.8 (42,000)	NS
UNINSURED PART YEAR	6.0 (157,000)	NS	6.4 (39,000)	— **
POPULATION IN 2003	100% 2,625,000	N/A	100% 611,000	N/A

Note: Numbers may not add to 100% due to rounding.
Note: Totals will not exactly match administrative data due to survey methodology and timeframe. See Appendix for full discussion.
N/A = Not applicable
NS = No statistically significant change from 2001.
i Change in percentage points, not in the percent of the total estimate. Change is from reweighted 2001 California Health Interview Survey.
+/— ** = Direction of change from 2001, change is statistically significant at $p < 0.05$.
Source: 2001-R and 2003 California Health Interview Surveys

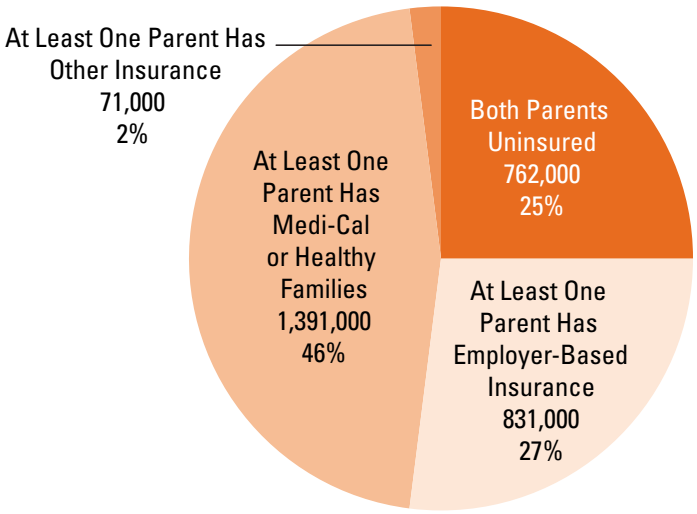
percentage who were continuously enrolled in 2001 (Exhibit 22).[18] More than nine out of 10 Medi-Cal enrollees are continuous enrollees from one year to the next. During the previous 12 months, Medi-Cal added 157,000 children who had been uninsured and 61,000 who had been covered by other public programs or by private health insurance.

More than nine out of 10 Medi-Cal enrollees are continuous enrollees from one year to the next.

However, while 86.8% of current Healthy Families enrollees in 2003 were also continuously enrolled for at least a year, this was a significantly higher percentage than in 2001 (Exhibit 22). In this exhibit, we present only the direction of change because the small sample sizes involved sometimes yield deceptively large but statistically insignificant changes. An additional 42,000 current Healthy Families enrollees had some other insurance for part of the year. The proportion of Healthy Families enrollees who were uninsured for part of the previous year significantly decreased to just 6.4% of current Healthy Families enrollees (39,000). This change shows how the Healthy Families enrollee population is increasingly retaining coverage for the full year.

18 Note that these totals do not match overall administrative data counts for enrollment in Medi-Cal or Healthy Families. Please refer to the Appendix for a discussion of the differences between the California Health Interivew Survey used for this report and administrative data enrollment counts.

EXHIBIT 23. INSURANCE TYPES/STATUS OF PARENTS OF CURRENT MEDI-CAL AND HEALTHY FAMILIES ENROLLEES, AGES 0-17, CALIFORNIA, 2003



Note: Age range is 0-17 because the CHIS interview does not collect information about the insurance status of the parents of 18-year-olds.

Source: 2003 California Health Interview Survey

PARENTS OF CURRENT MEDI-CAL AND HEALTHY FAMILIES ENROLLEES

As discussed in earlier sections of this report, the number of children enrolled in Medi-Cal and Healthy Families increased dramatically and more than counter-balanced the losses from job-based coverage, while adults' public coverage remained flat. In light of that trend, examining the insurance status of the parents of current Medi-Cal and Healthy Families enrollees illuminates whether or not there are uninsured parents who could have been protected if they, like their children, had been able to enroll in public insurance programs.

In Exhibit 23, the largest piece of the pie (46%) represents children who have parents also covered through Medi-Cal (or, for teenage parents, Healthy Families). Another 29% of children enrolled in Medi-Cal or Healthy Families have at least one parent who has some form of other health insurance, with the vast majority being covered through their employer.

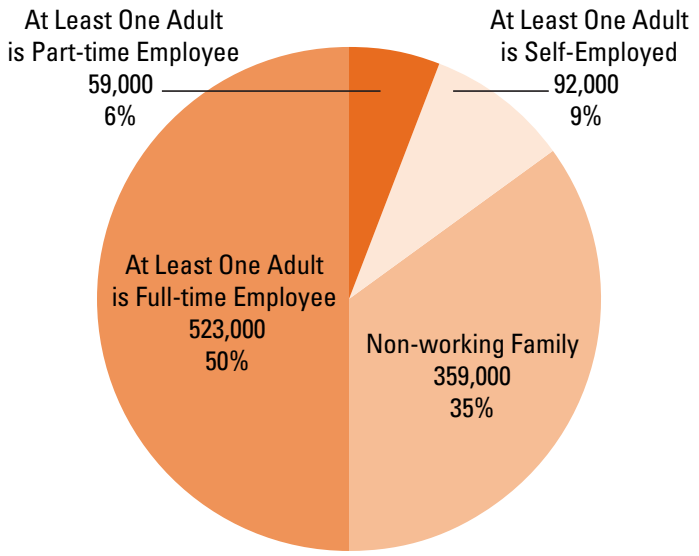
However, fully one-fourth of children enrolled in Medi-Cal or Healthy Families have parents who are both uninsured. Many low-income families have children that qualify for public coverage but their parents do not as a result of the very restrictive eligibility requirements for adults. The income restrictions apply even within the same family, resulting in many families in which not all members have the same insurance type or even the same status.

Among all children with Healthy Families coverage, nearly half have parents who are both uninsured (45.5%; data not shown). This high rate of uninsurance illustrates the immense need to implement and fund the approved Healthy Families expansion to cover parents as well as their children.

One-fourth of children enrolled in Medi-Cal or Healthy Families have parents who are both uninsured.

The majority of children who receive Medi-Cal or Healthy Families are from working families, contrary to the myth that these are mostly non-working families on welfare. Two out of three children with Medi-Cal or Healthy Families have at least one working adult in the

EXHIBIT 24. FAMILY WORK STATUS AMONG CURRENT MEDI-CAL AND HEALTHY FAMILIES ENROLLEES, AGES 0-18, CALIFORNIA, 2003



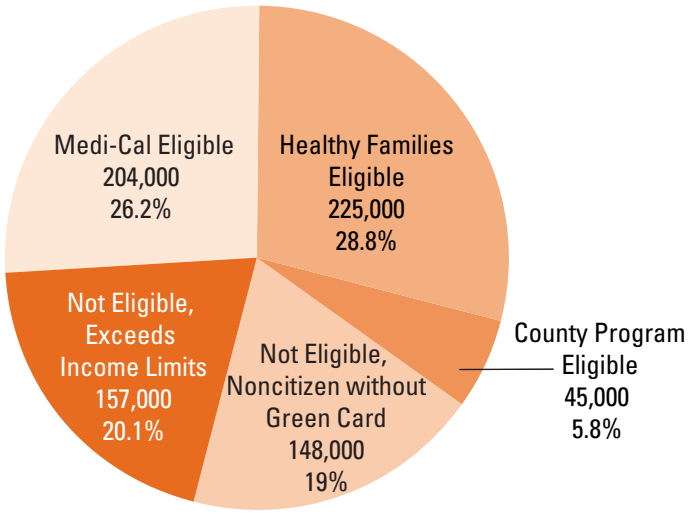
Total number of current Medi-Cal and Healthy Families enrollees (Ages 0-18) = 3,236,000

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

Note: "Full-time Employee Family" includes at least one full-time worker; "Part-time Employee Family" includes at least one part-time worker and no full-time workers; "Self-employed Family" includes at least one person who is self-employed and no employees; "Non-working Family" includes persons in families with no working adult (includes unemployed, students, retired, or temporarily or permanently disabled persons).

Source: 2003 California Health Interview Survey

EXHIBIT 25. ELIGIBILITY FOR MEDI-CAL, HEALTHY FAMILIES AND COUNTY HEALTH INSURANCE PROGRAMS AMONG CHILDREN UNINSURED AT TIME OF INTERVIEW, AGES 0-18, CALIFORNIA, 2003



779,000 children uninsured at time of CHIS 2003 interview

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

Source: 2003 California Health Interview Survey

household (Exhibit 24). Only 9% of children enrolled in Medi-Cal or Healthy Families have parents who are self-employed.

Among children with only Healthy Families coverage, nearly three-fourths live in a household with at least one parent working full-time (73.6%; data not shown). Only 14.4% live in a non-working family.

UNINSURED CHILDREN ELIGIBLE FOR MEDI-CAL OR HEALTHY FAMILIES

To estimate the number of children who are eligible for public programs, we use data about uninsured children's family income and other eligibility criteria as they were at the time of the CHIS interview. As Medi-Cal and Healthy Families enrollment of children dramatically expanded, the overall number of uninsured children at the time of the CHIS interview dropped significantly—from 1,017,000 in 2001 to 779,000 in 2003.

EXHIBIT 26. INSURANCE COVERAGE OVER PAST 12 MONTHS AMONG CURRENTLY UNINSURED CHILDREN, AGES 0-18, CALIFORNIA, 2001 AND 2003

	ELIGIBLE FOR MEDI-CAL AT THE TIME OF CHIS INTERVIEW		ELIGIBLE FOR HEALTHY FAMILIES AT THE TIME OF CHIS INTERVIEW		NOT ELIGIBLE FOR FOR MEDI-CAL OR HEALTHY FAMILIES AT THE TIME OF CHIS INTERVIEW	
	2003 (POPULATION)	**CHANGE FROM 2001[i]**	**2003 (POPULATION)**	**CHANGE FROM 2001**	**2003 (POPULATION)**	**CHANGE FROM 2001**
UNINSURED ALL YEAR	**66.0 (135,000)**	**NS**	**52.4 (118,000)**	**—****	**72.4 (253,000)**	**NS**
UNINSURED PART YEAR	**33.9 (69,000)**	**NS**	**47.6 (107,000)**	**+****	**27.6 (97,000)**	**NS**
HAD MEDI-CAL, BECAME UNINSURED	15.9 (33,000)	NS	20.3 (46,000)	+**	9.5 (33,000)	+*
HAD EMPLOYER-BASED INSURANCE, BECAME UNINSURED	***	***	16.2 (36,000)	NS	8.0 (28,000)	NS
HAD OTHER INSURANCE BECAME UNINSURED	9.0 (18,000)	NS	11.1 (25,000)	NS	10.1 (36,000)	NS
POPULATION IN 2003	**100% 204,000**	**N/A**	**100% 225,000**	**N/A**	**100% 350,000**	**N/A**

Note: Numbers may not add to 100% due to rounding.
N/A = Not applicable
NS = No statistically significant change from 2001.
+/— * = Direction of change from 2001, and change is statistically significant at $p < 0.1$.
+/— ** = Direction of change from 2001, and change is statistically significant at $p < 0.05$.
*** = Estimate is unstable because coefficient of variation is over 30%.
i Change in percentage points, not in the percent of the total estimate. Change is from reweighted 2001 California Health Interview Survey.
Source: 2001-R and 2003 California Health Interview Surveys

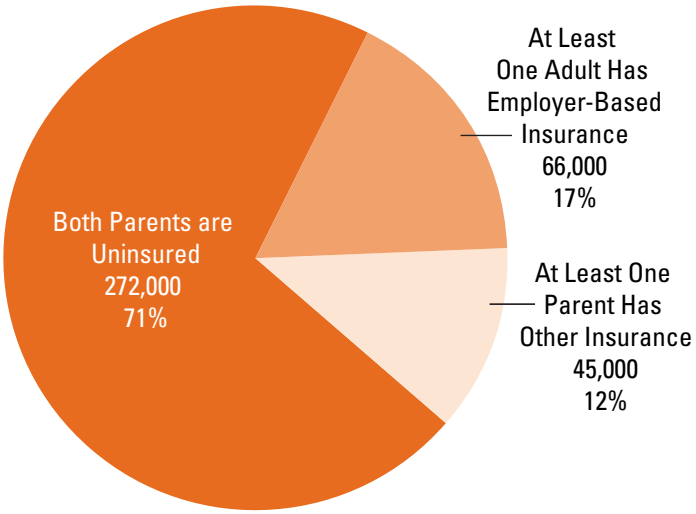
A little more than half of all uninsured children (55%) were eligible for enrollment in either Medi-Cal or Healthy Families. Approximately 204,000 uninsured children were eligible for Medi-Cal and another 225,000 were eligible for the Healthy Families Program (Exhibit 25).

Two out of three children with Medi-Cal or Healthy Families have at least one working adult in the household.

Another 44,000 children were eligible for insurance through county-based insurance programs in 2003, a number that has grown to nearly 116,000 by the end of 2004 as new county programs have opened their doors. These local programs cover low- to moderate-income children who do not qualify for employment-based insurance, Medi-Cal or Healthy Families. However, because most of the county programs have reached their maximum enrollment caps, the opportunities for eligible children to enroll are actually very limited. Current county-level programs would accommodate far fewer children than the number that are eligible.

Another 159,000 uninsured children are citizens or permanent residents who are ineligible for any of these public programs because their family incomes exceed the limits in Healthy

EXHIBIT 27. INSURANCE TYPES/STATUS OF PARENTS OF CURRENTLY UNINSURED CHILDREN ELIGIBLE FOR MEDI-CAL AND HEALTHY FAMILIES, AGES 0-17, CALIFORNIA, 2003



Total number of uninsured children eligible for Medi-Cal or Healthy Families (Ages 0-17) = 383,000

Note: Age range is 0-17 because the CHIS interview does not collect information about the insurance status of the parents of 18-year-olds.

Source: 2003 California Health Interview Survey

Families and other public programs. Finally, 148,000 uninsured children were ineligible because of their immigration status.

Among these uninsured eligible children, the proportion of children who were uninsured all year but eligible for Medi-Cal at the time of their interview has remained fairly stable from 2001 to 2003 (Exhibit 26). In contrast, the proportion of children who are eligible for Healthy Families is increasingly comprised of those who were once on Medi-Cal or other insurance. They are less likely to be those who were uninsured all year.

This change in the mix of childrens' insurance status shows that Healthy Families has made significant gains in enrolling children who previously had no insurance at all. However, it also illustrates the importance of creating a seamless bridge from Medi-Cal to Healthy Families.

PARENTS OF UNINSURED CHILDREN ELIGIBLE FOR MEDI-CAL AND HEALTHY FAMILIES

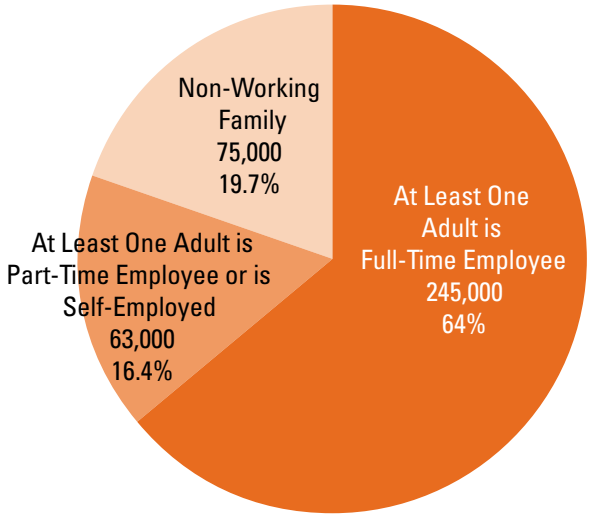
The overwhelming majority of uninsured children who are eligible for Medi-Cal or Healthy Families have parents who are themselves uninsured (71%; Exhibit 27). Nearly one-third of children who are uninsured but eligible for Medi-Cal or Healthy Families have parents who have private insurance (29%). This population is fairly evenly divided between those who have employer-based insurance (17%) and those with privately purchased or some other public coverage (12%).

Eight in 10 uninsured eligible children have parents who are workers; only 19.7% are in non-working families (Exhibit 28). Nearly two-thirds of these uninsured children (245,000) have parents with full-time jobs, but no health benefits for their children from those jobs.

The overwhelming majority of uninsured children who are eligible for Medi-Cal or Healthy Families have parents who are themselves uninsured.

Only 6% of uninsured adults overall are themselves eligible for Medi-Cal, but this translates to insurance for just under 250,000 adults, mostly parents of Medi-Cal enrollees (data not shown). Additionally, as noted in Exhibit 20, coverage for parents through Healthy Families has been approved by the California state legislature as well as the federal government,

EXHIBIT 28. FAMILY WORK STATUS AMONG CURRENTLY UNINSURED CHILDREN ELIGIBLE FOR MEDI-CAL AND HEALTHY FAMILIES, AGES 0-18, CALIFORNIA, 2003



Total number of uninsured children eligible for Medi-Cal or Healthy Families (Ages 0-18) = 429,000

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

Note: "Full-time Employee Family" includes at least one full-time worker; "Part-time Employee Family" includes at least one part-time worker and no full-time workers; "Self-employed Family" includes at least one person who is self-employed and no employees; "Non-working Family" includes persons in families with no working adult (includes unemployed, students, retired, or temporarily or permanently disabled persons).

Source: 2003 California Health Interview Survey

but has not been implemented due to funding shortages. Funding this program would allow another 377,000 (9.2% of uninsured adults) to access health insurance through the same source as their children.

WHY AREN'T ELIGIBLE UNINSURED CHILDREN ENROLLED?

Parents report a variety of reasons as to why their uninsured children who, by our calculations would be eligible for Medi-Cal or Healthy Families, are not enrolled in the programs. Nearly one-third of parents of Medi-Cal eligible children reported that they didn't think their children were eligible for the program (30.9%; data not shown). Most of these people thought that their household incomes were too high (15%), when in reality—by our calculations—their children would be eligible for Medi-Cal.

Healthy Families has made considerable progress in making its existence known to parents. Among parents of children who are uninsured but eligible for Healthy Families, only 9.1% reported that they "didn't know it [Healthy Families] existed," 12.3 percentage points less than in 2001 (data not shown). During this time period, Healthy Families has become a much more established and well-known program, which can only enhance its ability to further reach uninsured eligible children.

Over one-fourth of parents of uninsured children who are eligible for Healthy Families, however, do not believe that they would be able to enroll in the program (26.8%; data not shown). Combined with the 11.2% who didn't know if they were eligible, more than one-third of uninsured children eligible for Healthy Families are not enrolled because of confusion about the program's requirements.

Nearly two-thirds of uninsured children have parents with full-time jobs, but these parents have no health benefits for their children from those jobs.

Clearly, Medi-Cal and Healthy Families have made great strides in enrolling and retaining eligible children, but they also can make further progress in reaching families and making them aware of their children's potential eligibility.

4. THE ACCESS AND HEALTH CONSEQUENCES OF COVERAGE

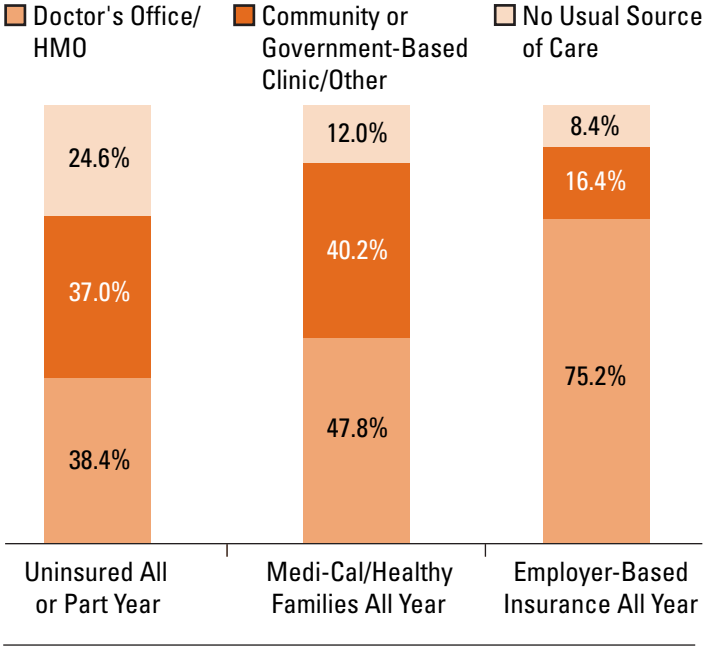
What are the consequences for Californians of having health insurance coverage—or lacking it—for either a short or long period of time? Recent thorough reviews of the literature by the Institute of Medicine[19] and Hadley[20] show that the uninsured have poorer access to health care providers, procedures and medicines; lower satisfaction; and poorer health outcomes. In this section we use CHIS 2003 and 2001 data to examine the relationship between insurance status and several aspects of access and health: having a usual source of care, reported-health status, access to doctors and delays in obtaining care, cancer screening, use of medications for chronic illnesses, satisfaction and perceived racial discrimination.

HAVING A USUAL SOURCE OF CARE

Having a usual source of care ensures that an individual has some connection to the health care system through which to obtain medical care when it is needed for preventive services and for acute and chronic conditions. However, despite overall poorer health status, the uninsured are less likely to have a usual source of care than the insured. In addition, even among those with a usual source of care, the uninsured are less likely to report that this source is a doctor's office or HMO.

Exhibit 29 shows the relationship between insurance status and usual source of care for children. Approximately one-quarter of uninsured children lack a usual source of care—more than double the rate among children with Medi-Cal/Healthy Families and nearly triple the rate among children with employer-based coverage. The uninsured are only half as likely to rely on a doctor's office or HMO as their usual source of care as children with employer based coverage. In addition, uninsured children and those with Medi-Cal/Healthy Families are twice as likely to list a community or government clinic as their usual source of care compared to children with employer-based coverage.

EXHIBIT 29. USUAL SOURCE OF CARE BY INSURANCE TYPE, AGES 0-17, CALIFORNIA, 2003



Note: Numbers may not add to 100% due to rounding.
Source: 2003 California Health Interview Survey

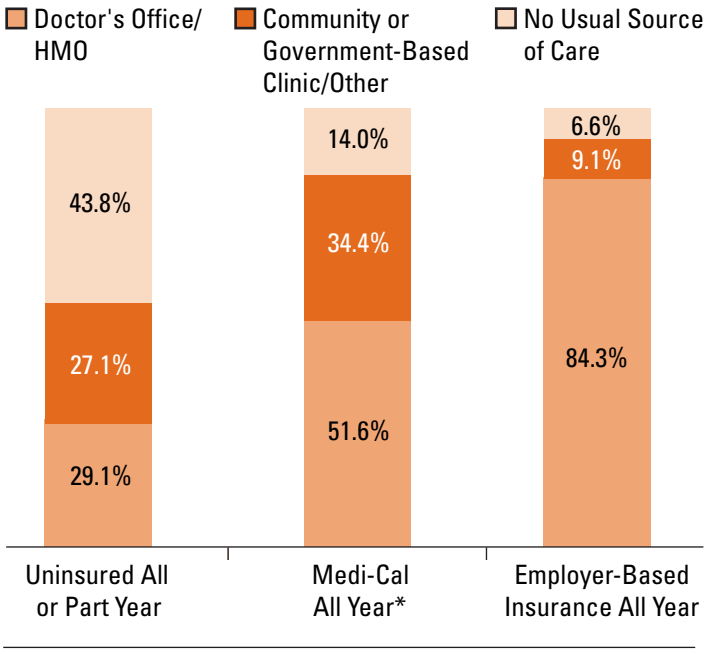
19 Institute of Medicine. *Care Without Coverage: Too Little, Too Late.* Washington, DC: National Academy Press, 2002.

20 Hadley, J. "Sicker and Poorer: The Consequences of Being Uninsured." *Medicare Care Research and Review*, 60 (2, Supplement), 2003: 3S – 75S.

These differences in usual source of care are even more dramatic for non-elderly adults, as shown in Exhibit 30. More than three times as many adults with Medi-Cal and more than six times as many uninsured adults lack a usual source of care compared to those with employer-based coverage. In addition, adults with employer-based coverage were nearly three times as likely to report a doctor's office as their usual source of care than were adults uninsured all or part of the year. Adults with employer-based coverage were only about one-third as likely to rely on a community or government clinic for their usual source of care as uninsured adults or those with Medi-Cal.

Despite overall poorer health status, the uninsured are less likely to have a usual source of care than the insured.

EXHIBIT 30. USUAL SOURCE OF CARE BY INSURANCE TYPE, AGES 18-64, CALIFORNIA, 2003



Note: Numbers may not add to 100% due to rounding.
* Also includes 18-year-olds that were enrolled in Healthy Families all year.
Source: 2003 California Health Interview Survey

SELF-REPORTED HEALTH STATUS

Exhibit 31 shows the major differences in self-reported health status for those with different insurance coverage types. Children with employer-based coverage were in far better health than either the uninsured or those with Medi-Cal/Healthy Families. Over three-quarters of those with employment-based insurance all year (76.7%) had excellent or very good health, and just one in twenty (4.6%), fair or poor health. In contrast, only half of children who were uninsured all or part of the year (50.2%) were in excellent or good health, and nearly one in seven (13.3%) had fair or poor health.

The pattern is very similar for adults. Nearly two-thirds with employer-based coverage (63.7%) say their health is excellent or very good, compared to just 38.5% of those uninsured all or part of the year, and 30.3% of those with Medi-Cal. And just one-tenth of those with employer-based insurance (10.6%) say their health is fair or poor; rates for the uninsured are nearly triple (27.3%) and for those on Medi-Cal, nearly quadruple (39.5%).

These findings do not imply that lack of insurance (or Medi-Cal) *causes* lower self-assessed health status. What they do point to, however, is that these groups are likely to have greater health care needs. Yet, as shown in the following section of this chapter, the uninsured tend to receive fewer—not more—needed health care services than their healthy counterparts who have employer-based coverage.

EXHIBIT 31. SELF-REPORTED HEALTH STATUS BY AGE GROUP AND INSURANCE TYPE, AGES 0-64, CALIFORNIA, 2003

	SELF-REPORTED HEALTH STATUS							
	CHILDREN, AGES 0-17				ADULTS, AGES 18-64			
	EXCELLENT/ VERY GOOD	GOOD	FAIR/ POOR	TOTAL	EXCELLENT/ VERY GOOD	GOOD	FAIR/ POOR	TOTAL
UNINSURED ALL OR PART YEAR	50.2	36.5	13.3	100%	38.5	34.2	27.3	100%
MEDI-CAL/HEALTHY FAMILIES ALL YEAR	53.8	31.8	14.4	100%	30.3	30.2	39.5	100%
EMPLOYER-BASED INSURANCE ALL YEAR	76.7	18.7	4.6	100%	63.7	25.7	10.6	100%

Note: Numbers may not add to 100% due to rounding.
Source: 2003 California Health Interview Survey

ACCESS TO CARE

This section focuses on four aspects of access to health care: 1) length of time since visiting a doctor; 2) delays in obtaining care; 3) preventive cancer screenings; and 4) use of medications for chronic illnesses. Exhibit 32 shows that insured children and adults have the most recent contact with physicians. Over nine in 10 children with Medi-Cal, Healthy Families or employer-based coverage saw a physician in the past year, rates that were 10 percentage points higher than for children who were uninsured all or part of the year. Similarly, the percentage of uninsured children who have not visited a physician for more than two years (5.3%) was four times as high as those with employer-based coverage (1.3%) and nine times as high as those with Medi-Cal or Healthy Families coverage (0.6%). These

EXHIBIT 32. LENGTH OF TIME SINCE LAST DOCTOR VISIT BY AGE GROUP AND INSURANCE STATUS, AGES 0-64, CALIFORNIA 2003

	TIME SINCE LAST DOCTOR VISIT							
	CHILDREN, AGES 0-11[i]				ADULTS, AGES 18-64			
	LESS THAN 1 YEAR	1 TO 2 YEARS	MORE THAN 2 YEARS	TOTAL	LESS THAN 1 YEAR	1 TO 2 YEARS	MORE THAN 2 YEARS	TOTAL
UNINSURED ALL OR PART YEAR	83.7	11.0	5.3	100%	64.8	13.6	21.6	100%
MEDI-CAL/HEALTHY FAMILIES ALL YEAR	95.4	4.0	0.6	100%	86.3	7.2	6.5	100%
EMPLOYER-BASED INSURANCE ALL YEAR	94.1	4.7	1.3	100%	86.4	7.2	6.5	100%

Note: Numbers may not add to 100% due to rounding.
i Question in the survey asked of respondents ages 0-11 only.
Source: 2003 California Health Interview Survey

EXHIBIT 33. DELAYS OF HEALTH CARE BY AGE GROUP AND INSURANCE STATUS, AGES 0-64, CALIFORNIA, 2001 AND 2003

	CHILDREN, AGES 0-17				ADULTS, AGES 18-64			
	DELAYED GETTING PRESCRIPTION[i]		DELAY OF ANY OTHER CARE		DELAYED GETTING PRESCRIPTION		DELAY OF ANY OTHER CARE	
	2003	CHANGE FROM 2001[ii]	2003	CHANGE FROM 2001	2003	CHANGE FROM 2001	2003	CHANGE FROM 2001
UNINSURED ALL OR PART YEAR	8.5%	+4.1**	13.3%	+4.5**	12.2%	+3.4**	21.0%	+0.9
MEDI-CAL/HEALTHY FAMILIES ALL YEAR	5.5%	+3.4**	7.4%	+2.8**	18.1%	+6.6**	18.0%	+5.5**
EMPLOYER-BASED INSURANCE ALL YEAR	2.7%	+0.1	5.2%	+1.6**	11.0%	+1.8**	13.4%	+0.8**

Note: Numbers are individual rates and will not add to 100%.
i Question asked about respondents ages 0-11 only.
ii Change in percentage points, not in the percent of the total estimate. Change is from reweighted 2001 California Health Interview Survey.
* Change is statistically significant at $p < 0.1$.
** Change is statistically significant at $p < 0.05$.
Source: 2001-R and 2003 California Health Interview Surveys

disparities are disturbing because uninsured children had considerably poorer reported health status than those with employer-based coverage. The patterns among adults were just as pronounced, with those uninsured all or part of the year far more likely to have gone two years without seeing a doctor (21.6%) than those with Medi-Cal or employer-based coverage (both 6.5%).

Delays in Obtaining Care

Exhibit 33 examines delays in obtaining health care—getting a prescription and any other type of care—for both children and adults. It also shows how the frequency of reported delays changed between 2001 and 2003. In general, delays were more common among adults than children, reflecting the fact that parents are less likely to cut back on pediatric care.

Over nine in 10 children with Medi-Cal, Healthy Families or employer-based coverage saw a physician in the past year, rates that were 10 percentage points higher than for children who were uninsured all or part of the year.

Nevertheless, those who were uninsured all or part of the year were more likely to report delays than the insured, regardless of age. To illustrate, 8.5% of uninsured children delayed obtaining a prescription in 2003, compared to 2.7% of those with employer-based coverage (Exhibit 30). Among adults, 21% of the uninsured reported delaying other care, versus 13.4% of those with employer-based insurance. In both cases, those with Medi-Cal/Healthy Families had rates falling somewhere in between these percentages (Exhibit 33).

Moreover, Exhibit 33 shows that the proportion of children and adults who delayed prescriptions or care increased from 2001 to 2003. The increase in the percentage of individuals

EXHIBIT 34. PERCENT REPORTING SELECTED CANCER SCREENINGS BY INSURANCE STATUS, AGES 18-64, CALIFORNIA, 2003

	MAMMOGRAM WITHIN THE PAST TWO YEARS[i]	PAP TEST WITHIN THE PAST THREE YEARS[i]	PSA WITHIN THE PAST YEAR[i]	COLONOSCOPY SIGMOIDOSCOPY OR FOBT WITHIN THE PAST FIVE YEARS[i]
UNINSURED ALL YEAR	52.5%	74.8%	5.6%	19.7%
UNINSURED PART YEAR	60.6%	84.8%	11.5%	36.6%
MEDI-CAL ALL YEAR[ii]	69.5%	84.1%	17.2%	41.7%
EMPLOYER-BASED INSURANCE ALL YEAR	80.9%	89.8%	26.1%	51.1%

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

i Mammogram rates for women, ages 40-64; Pap Test rates for women, ages 18-64; PSA Test rates for men, ages 40-64; Colonoscopy/Sigmoidoscopy/FOBT rates for adults, ages 50-64.

ii Also includes 18-year-olds that were enrolled in Healthy Families all year.

Source: 2003 California Health Interview Survey

reporting a delay tended to be greater for the uninsured and for Medi-Cal/Healthy Families than for those with employer-based coverage. To cite one example, among children, reported rates of delay for other care by the uninsured rose by 4.5 percentage points, compared to a rise of 1.6 percentage points for those with employer coverage (Exhibit 33). Although uninsured children and adults are not much more likely to report a delay in filling a prescription than those with private insurance, the uninsured are much less likely to see a doctor and, therefore, less likely to have a prescription that needs to be filled.

Those who were uninsured all or part of the year were more likely to report delays than the insured, regardless of age.

Preventive Cancer Screening

Exhibit 34 shows the rates of selected cancer screenings by insurance status for adults of recommended age. Women between the ages of 40 and 64 with employer-based coverage were more likely than the uninsured or those with Medi-Cal to report a mammogram within the past two years. Rates of cervical cancer screening among women between the ages of 18 and 64 are comparable across insurance groups (Exhibit 34). However, women with at least some form of insurance coverage during the year reported higher rates of screening than those who were uninsured all year.

Adults between the ages of 50 and 64 are more likely to report colon cancer screening within the past five years if they had at least some type of insurance coverage during the year. In fact, rates of colon cancer screening in the past five years for adults with employer-based or Medi-Cal coverage all year are more than double that of adults uninsured all year (Exhibit 34).

EXHIBIT 35. PERCENT RESPONDENTS WITH ASTHMA BY AGE GROUP, ACCESS INDICATOR AND INSURANCE TYPE, AGES 0-64, CALIFORNIA, 2003

	CHILDREN, AGES 0-17		ADULTS, AGES 18-64	
	ASTHMA PREVALENCE	TAKING MEDICATION FOR ASTHMA[i]	ASTHMA SYMPTOM PREVALENCE[ii]	TAKING MEDICATION FOR ASTHMA[i]
UNINSURED ALL OR PART YEAR	4.9%	46.2%	5.7%	37.8%
MEDI-CAL/HEALTHY FAMILIES ALL YEAR	9.2%	45.1%	10.8%	58.4%
EMPLOYER-BASED INSURANCE ALL YEAR	10.5%	35.3%	7.2%	42.2%

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

i Percentage among those either with asthma (ages 0-17) or with asthma and had symptoms in the past year (ages 18-64).

ii "Asthma Symptom Prevalence" refers to the percent of the total adult population who have experienced asthma symptoms in the past year. Since many adults outgrow childhood asthma, this measure is a better indicator of the disease for ages 18-64.

Source: 2003 California Health Interview Survey

Men between the ages of 50 and 64 with employment-based coverage are nearly five times more likely than adults uninsured all year—and more than twice as likely as those uninsured part of the year—to report a PSA within the past year (Exhibit 34). Overall, however, rates of PSA within the past year remain relatively low across all insurance groups with only 6 to 26% of men receiving the test, which is not as concerning as low rates for the other cancer screenings because the efficacy of PSA screening is not well established.

Use of Medications for Chronic Illnesses

CHIS 2003 also examines the frequency with which individuals with chronic illnesses take recommended medications. For asthma, both children and adults are included (Exhibit 35), whereas for diabetes and high blood pressure, rates are available for adults only (Exhibit 36).[21]

Each exhibit shows the proportion of Californians who have the condition, and among those, the percentage taking recommended medications.

There is little apparent relationship between insurance coverage and medication usage for asthma.[22] Curiously, fewer children (35.3%) with employer-based coverage are taking medications than their counterparts with Medi-Cal/Healthy Families (45.1%; Exhibit 35). However, the difference between these children and those uninsured all or part of the year (46.2%) is not statistically significant due to small sample sizes. The only pattern seen among adults is that those with Medi-Cal are more likely (58.4%) to be taking medications for asthma than are those with employer-based coverage (42.2%) or the uninsured (37.8%; Exhibit 35).

21 CHIS 2003 does inquire about diabetic children but there is not a sufficient sample size among the different insurance groups to make valid comparisons.

22 The questions relating to taking medication for asthma changed significantly from CHIS 2001 to CHIS 2003. Direct comparisons cannot be made between the rates for these two years.

EXHIBIT 36. RESPONDENTS WITH SELECTED CHRONIC DISEASES BY ACCESS INDICATOR AND INSURANCE TYPE, AGES 18-64, CALIFORNIA, 2003		
	SELECTED CHRONIC DISEASE[i]	ACCESS INDICATOR[ii]
	DIABETES PREVALENCE	TAKING INSULIN OR PILLS FOR DIABETES
UNINSURED ALL YEAR	4.3%	71.3%
UNINSURED PART YEAR	3.5%	77.3%
MEDI-CAL ALL YEAR[iii]	10.3%	81.9%
EMPLOYER-BASED INSURANCE ALL YEAR	4.4%	77.4%
	HIGH BLOOD PRESSURE PREVALENCE	TAKING MEDICATION FOR HIGH BLOOD PRESSURE
UNINSURED ALL YEAR	13.7%	34.9%
UNINSURED PART YEAR	14.3%	32.8%
MEDI-CAL ALL YEAR[iii]	25.5%	59.6%
EMPLOYER-BASED INSURANCE ALL YEAR	18.2%	60.7%

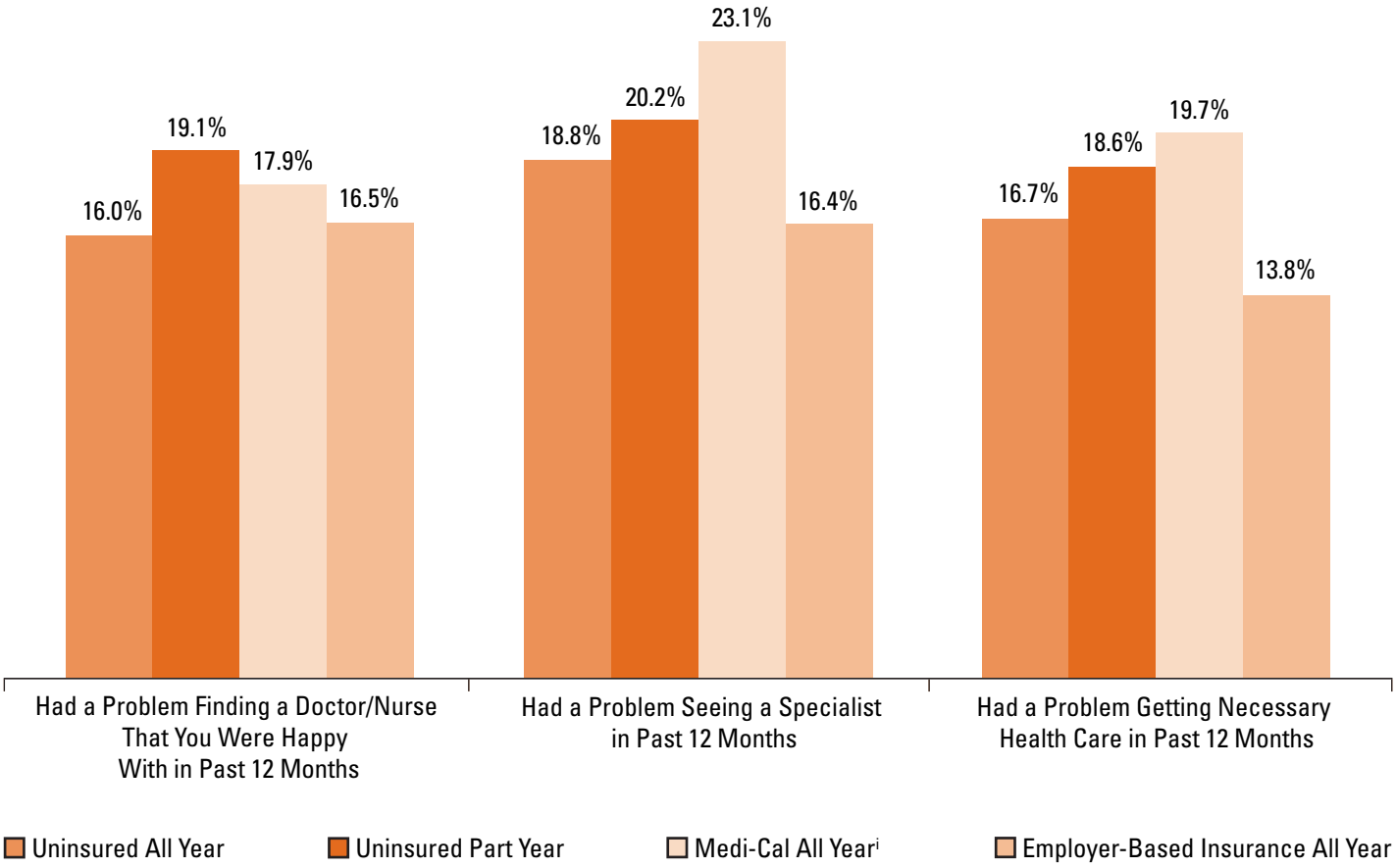
Note: Numbers are individual rates and will not add to 100%.
i Rate among whole population.
ii Rate among those with the chronic disease.
iii Also includes 18-year-olds that were enrolled in Healthy Families all year.
Source: 2003 California Health Interview Survey

Rates of taking insulin or pills for diabetes among adults are fairly similar by insurance category, with the only notable difference being that those uninsured all year long are less likely to be taking medications (71.3%) than those who are insured (Exhibit 36). In contrast, there is a dramatic difference among those with high blood pressure. About 60% of those with employer-based coverage or Medi-Cal take blood pressure medications, compared to just one-third of those uninsured all or part of the year (33-35%; Exhibit 36).

PROBLEMS WITH CARE

In the CHIS 2003 interview, adult respondents were asked whether or not they had any problems in finding a personal physician with whom they were satisfied, in seeing a specialist or in getting any other needed care over the past year. While these questions were asked of the entire population, Exhibits 37 and 38 show the rates only among those who said that they needed either a physician, a specialist or any care over the past year.

EXHIBIT 37. PROBLEMS WITH ACCESS TO CARE BY INSURANCE STATUS, AGES 18-64, CALIFORNIA, 2003



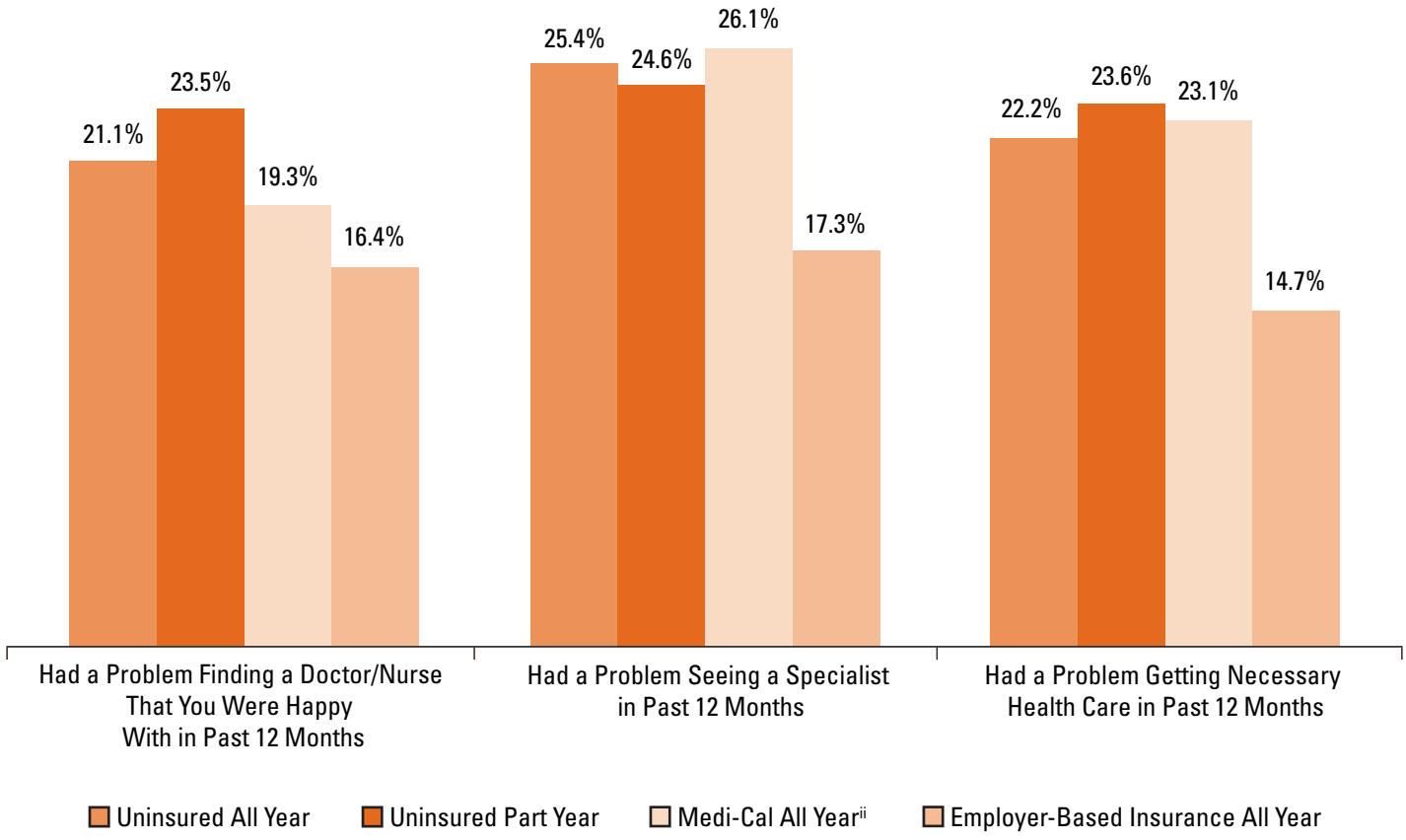
Note: Numbers are individual rates and will not add to 100%.
i Also includes 18-year-olds that were enrolled in Healthy Families all year.

Source: 2003 California Health Interview Survey

The satisfaction problems reported among the entire adult population are shown in Exhibit 37. Those with employer-based insurance report the fewest problems with both seeing a specialist (16.4%) and getting necessary health care (13.8%). There were no statistically significant differences in the rates of having problems finding a satisfactory doctor or nurse.

Exhibit 38 shows the proportions of adults with problems finding care among those who have been diagnosed with a chronic condition (asthma, diabetes or heart disease). The pattern here is similar to the general adult population in that

EXHIBIT 38. PROBLEMS WITH ACCESS TO CARE AMONG ADULTS WITH A CHRONIC CONDITION[i] BY INSURANCE STATUS, AGES 18-64, CALIFORNIA, 2003



Note: Numbers are individual rates and will not add to 100%.
i Includes adults with asthma, diabetes, or heart disease.
ii Also includes 18-year-olds that were enrolled in Healthy Families all year.
Source: 2003 California Health Interview Survey

those with employer-based insurance have the lowest rates of problems reported: finding a doctor or nurse (16.4%), seeing a specialist (17.3%), and getting necessary health care (14.7%).

EXHIBIT 39. FREQUENCY OF BEING TREATED BADLY BECAUSE OF RACE/ETHNICITY BY RACIAL/ETHNIC GROUP, AGES 18-64, CALIFORNIA, 2003

	RACIAL/ETHNIC GROUP					
	WHITE	LATINO	ASIAN AMERICAN AND PACIFIC ISLANDER	AFRICAN AMERICAN	AMERICAN INDIAN/ ALASKA NATIVE	OTHER AND MULTIPLE RACE
NEVER	54.4	45.2	33.2	14.2	40.0	39.9
RARELY	32.4	23.5	36.9	27.6	26.2	31.4
SOMETIMES	10.9	26.7	26.9	42.9	22.2	22.5
OFTEN/ALL THE TIME	2.3	4.6	3.0	15.3	11.7	6.2
TOTAL	100%	100%	100%	100%	100%	100%

Note: Numbers may not add to 100% due to rounding.
Source: 2003 California Health Interview Survey

PERCEIVED RACIAL DISCRIMINATION

Racial discrimination, whether objectively present or subjectively perceived, is another recognized barrier to health care.[23] When we examined the data, we found that no significant differences existed among insurance groups in the level of perceived racial discrimination. For Exhibits 39 and 40, we analyze differences by racial and ethnic group, without regard to insurance status but keeping in mind that uninsured groups include greater proportions of Latinos in California than the general population.

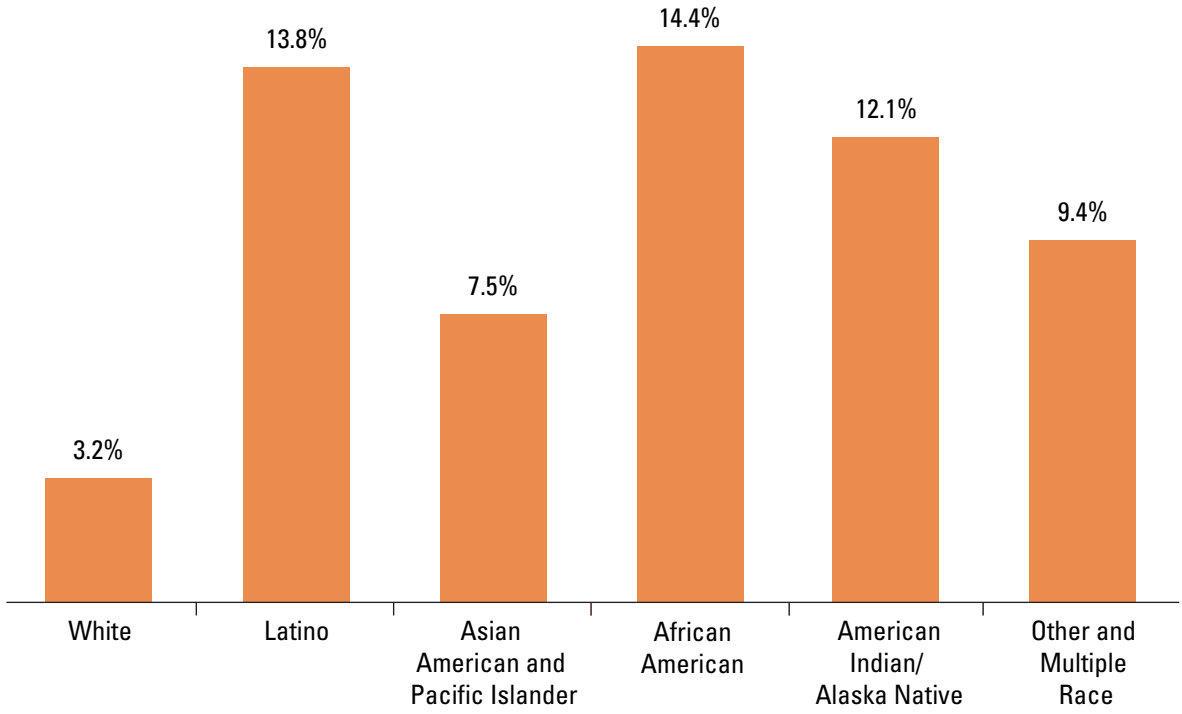
A slight majority of whites in California have felt that they were never treated badly or unfairly because of their race or ethnicity (54.4%; Exhibit 39), but majorities in all other groups have felt discrimination. African Americans by far have the highest rate of feeling discrimination "sometimes" or "often" at 58.2%. In comparison, only 31.3% of Latinos reported sometimes or often being treated badly because of their race or ethnicity, with 45.2% saying that they never have experienced discrimination (Exhibit 39).

African Americans by far have the highest rate of feeling discrimination "sometimes" or "often" at 58.2%. In comparison, only 31.3% of Latinos reported sometimes or often being treated badly because of their race or ethnicity, with 45.2% saying that they never have experienced discrimination.

Examining the percent of people who feel they would have received better medical care had they been a different race or ethnicity reveals a different side to this picture. While

23 Institute of Medicine. *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care.* Washington, DC: National Academy Press, 2002.

EXHIBIT 40. PERCENT REPORTING THEY WOULD HAVE RECEIVED BETTER MEDICAL CARE IF THEY WERE A DIFFERENT RACE/ETHNICITY BY RACIAL/ETHNIC GROUP, AGES 18-64, CALIFORNIA, 2003



Note: Numbers are individual rates and will not add to 100%.
Source: 2003 California Health Interview Survey

whites are still the lowest, with only 3.2% saying they would have been treated better if they were of a different group, 13.8% of Latinos and 14.4% of African Americans agreed (Exhibit 40). However, although different minority groups have similar rates of agreeing with this statement, these rates are much lower than those who feel they were treated badly because of their race or ethnicity. Although the reasons for this are unknown, it is possible that Californians don't necessarily think that others in different groups are getting treated any better than they are.

5. CONCLUSION: WHERE DO WE GO FROM HERE?

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The problems in California's and the nation's health insurance arrangements continue to grow, despite the reduction in the rate of uninsurance for children in California in this period. California can take pride in the decline in children's uninsured rates. It is the direct result of enacting expanded coverage for children backed by a broad legislative and advocacy commitment, continuous fine-tuning of state and local public policies, and the vigorous implementation of these programs and policies by State and local public agencies, coalitions of children's advocacy and health care groups, and philanthropic foundations.

This important improvement in children's health insurance coverage is all the more remarkable because it coincides with a continuing decline in employment-based insurance for both adults and children. In this concluding section, we focus on the seemingly inexorable decline in job-based insurance—the bedrock of private health insurance—and several policy proposals that are on the agenda in California and the nation.

THE CONTINUING EROSION OF EMPLOYMENT-BASED INSURANCE

Employment-based insurance—the source of health care coverage for the majority of the nonelderly population—continues to erode for adults and children alike. Virtually all demographic groups in the state lost job-based insurance between 2001 and 2003. The drop in employment-based coverage was due to two factors: the slack labor market, and large increases in health insurance premiums, a consequence of rising health care costs.

After the long-run economic expansion of the latter 1990s, in 2001 the unemployment rate rose substantially and average earnings stagnated. Between 2001 and 2003, California's nonelderly labor force increased by 264,000 while its employment increased by just 5,000, driving up the state's unemployment rate.[24] There is some evidence that the less educated and lowest skilled part of the workforce disproportionately lost jobs faster than the more educated and skilled workers: between 2001 and 2003, the proportion of California workers with a high school education or less declined while the college-educated part of the workforce increased.[25]

This labor market trend could help explain the finding in this study that employees' own job-based insurance did not change between 2001 and 2003 while dependent coverage fell. As low-wage workers—who are least likely to get employment-based coverage—disproportionately lost jobs, they left behind better paid workers, who would be more likely to work for an employer that offers coverage.

Although the workers who remained were, on average, slightly better paid than those who lost jobs, incomes remained relatively flat during this period. As California's average annual unemployment rate rose from 5.4% to 6.8% between 2001 and 2003,[26] per capita income fell slightly in 2002 and rose a weak 1.7% in 2003, after rising annually between 4.1% and 8.8% annually from 1995 to 2000.[27]

24 *California Labor Market Review*, California Employment Development Department, Sacramento, CA, March 2005.

25 UCLA Center for Health Policy Research analyses of March 2002 and March 2004 Current Population Surveys. It is doubtful that average educational attainment of workers rose that quickly in California.

26 Annual Unemployment Rate, California, *http://www.dof.ca.gov/HTML/FS_DATA/LatestEconData/Data/Employment/Bbelf.xls*, accessed 05-03-05.

27 California Department of Finance, Economic Research Unit, 2004.

Although wage and salary incomes have risen only modestly, the cost of health care and health insurance has grown dramatically, making health insurance less affordable for employers to offer it to all their workers and dependents, and making it less affordable for workers who continued to be offered coverage. The average annual increase in health insurance premiums rose 13.4% between 2001 and 2002 and another 15.8% between 2002 and 2003—about seven times the annual increase in the Consumer Price Index in California.[28] Although the growth in health insurance premiums slowed to "just" 11.4% between 2003 and 2004, that increase is about 3.5 times the rate of inflation. The enduring factor that has been driving down job-based insurance over the longer run is the rising cost of health care.[29]

The enduring factor that has been driving down job-based insurance over the longer run is the rising cost of health care.

The nation's and California's economic decline and the seemingly inexorable growth in health costs have been increasing economic pressure on employers. In 2004, employee health benefits in California cost, on average, $3,685 for single-person coverage and a whopping $10,013 for family coverage.[30] The nation's bedrock industries are handicapped under this pressure, with both Ford Motor Company and General Motors reporting losses attributable, in part, to their growing health care costs for active and retired workers, in addition to their weakening sales and market shares. GM's health care costs hit $5.2 billion in 2004—adding $1,400 to the price of each car, and thus making cars made in the United States less competitive than those made in other countries that have national health programs, such as Canada, Japan and Germany.[31]

Employers have responded by shifting more of the costs for health insurance to their workers. On average, workers' share of health insurance premiums rose 10% in 2001 and another 14% in 2003 for single coverage. Family coverage costs rose 25% in 2001 and another 30% in 2003. The increase in total premiums, for family coverage especially, was compounded by the increasing share of premiums they had to pay. The average worker in California was asked to pay 79% more from their paycheck for family coverage in 2003 than in 2001—an average of more than $220 a month in 2003—although their paychecks had not grown by nearly as much. Employers have also cut benefits, increased workers' cost-sharing for services they obtain, increased deductibles, and raised the traditional caps on total out-of-pocket spending for covered benefits, all of this pushing up workers' out-of-pocket spending for health care despite their relatively flat wages.[32]

It is hardly surprising, then, that working families and individuals are losing job-based insurance. Given the hefty increase in the average worker's cost for family coverage, it is predictable that dependent coverage decreased between 2001 and 2003. The cost-controlling strategy that President Bush and many business groups have advocated is to move

28 *California Employer Health Benefits Survey 2004*, Oakland: California HealthCare Foundation and the Health Research and Educational Trust, 2004.

29 Gilmer T, Kronick R, "It's The Premiums, Stupid: Projections of the Uninsured through 2013," *Health Affairs*, 2005 Apr 5; (e-pub).

30 *California Employer Health Benefits Survey 2004.*

31 Hakim D and Peters JW, "Shares of G.M. Tumble on Issue of Health Care," *New York Times*, April 15, 2005; "GM Has $1.1 Billion Loss, Withdraws Forecast," *New York Times*, April 19, 2005; and "Ford Profit Drops 38 Percent," *New York Times*, April 20, 2005; Garsten E, "GM Health Care Bill Tops $60 Billion—Cost Adds $1,400 Per Vehicle, Hurts Competitiveness," *Detroit News*, March 11, 2004; Plungis J, "Big 3: Cut Health Costs—Detroit Automakers Lobby Washington Hard for Reforms; Medical Tab Reached $9.9B in '03," *Detroit News*, Aug. 18, 2004.

32 *California Employer Health Benefits Survey 2004.*

workers from comprehensive health insurance plans to catastrophic coverage plans, often paired with "health savings accounts." This strategy, an example of what has been dubbed "consumer-directed health care," has the effect of shifting financial risk from employers to workers and their families. Consumer-directed health care is designed to make patients and families more conscious of each dollar spent on health care by making them more directly responsible for the financial consequences of their health care utilization.

Until recently few workers have found such high-deductible heath plans attractive.[33] Recent evidence suggests that, nationally, high-deductible health plans have experienced rapid growth, as the number of covered lives more than doubled to one million persons between September 2004 and March 2005, according to America's Health Insurance Plans, the industry's trade association.[34] A significant share of this growth was in the individual market, contributing to rising rates of privately purchased health insurance reported in Chapter 1 of this report. The average annual deductible for individuals is $2,790 and the average share-of-cost for covered benefits is $2,857—a total of more than $5,600 in financial exposure—after paying premiums that average $1,204 for a 20-year old to $3,306 for a 55-year old. Family coverage has even more liability, totaling $10,593 in deductibles and out-of-pocket costs, with premiums averaging $2,772 for a 20-year old to $5,518 for a 55-year old.[35] Although many market-oriented economists and business groups are enthusiastic about such plans, there are three reasons to be concerned.

First, high-deductible heath plans impose financial incentives to delay or forgo care that could keep children and adults healthier. There is ample evidence from research and demonstration programs that imposing high cost-sharing (deductibles and copayments or co-insurance) reduces use of effective and appropriate medical care, as well as unnecessary medical care. There also is evidence that patients with chronic illnesses (such as diabetes, high blood pressure or asthma), particularly those with low or moderate incomes, reduce purchases of services, prescription drugs and devices that are essential to manage their conditions and prevent complications, disability or even death.[36]

The second cause for concern is the likely effect of these high-deductible health plans on personal finances of middle-class and lower-income Americans. There is substantial evidence that a large number of Americans are already underinsured. An estimated one-fourth to one-half of all personal bankruptcies in the United States are due to medical care costs. Between two-thirds and four-fifths of all these individuals had health insurance at the time they incurred their expenses, although persons with medical insurance were more likely than those without it to have suffered a recent lapse in coverage.[37] Problems paying for medical care go well beyond the more than 600,000 medical care debt-related bankruptcies in 2002, the majority of them affecting people with health insurance.

33 Gabel J, Rice T, *Understanding Consumer-Directed Health Care in California*, Oakland, CA: California HealthCare Foundation, August 2003.

34 "Number of HSA Plans Exceeded One Million in March 2005," Washington, DC: America's Health Insurance Plans, March 2005.

35 "Number of HSA Plans Exceeded One Million in March 2005."

36 Davis K, "Will Consumer-Directed Health Care Improve System Performance?" *Health Services Research*, 2004; 39 (4, Part II): 1219-1233.

37 Levitt JC, "Transfer of Financial Risk and Alternative Financing Solutions," *Journal of Health Care Finance 2004*; 30(4):21–32; Jacoby M, Sullivan T, Warren E, "Medical Problems and Bankruptcy Filings," Norton's Bankruptcy Adviser, 1, 2, 10 (May 2000); Himmelstein DU, Warren E, Thorne D, Woolhandler S, "Illness And Injury As Contributors To Bankruptcy," *Health Affairs*, 2005 Feb 2; [E-pub ahead of print].

There is growing evidence that many families with medical bills find it increasingly difficult to pay for them. A recent study by the Center for Studying Health System Change estimated that nearly 20 million families experienced problems paying the bills they got for medical care, leading nearly two-thirds of them to report difficulty paying for other basic necessities, such as rent, mortgage payments, transportation and food.[38] A recent Los Angeles Times story captured the problem in its sub-title: "to keep health coverage, more workers are cutting back on food, heat, and other necessities. Still, many of them eventually will lose the battle." The widespread marketing of high-deductible health plans will expose a growing number of Americans to even more financial liability related to health care expenses.

Finally, the jury is out as to whether high-deductible health plans and other forms of consumer-directed health care will, in fact, control the rate of growth in health care costs. More affluent patients are likely to reduce their use of some services, such as preventive care, but for other care perceived as necessary, their out-of-pocket spending is likely to increase. Once a patient has paid out required deductibles, there are no incentives to control expenditures. Since 20% of all persons account for 80% of all health care expenditures,[39] the nation's total health care spending may be only slightly affected. Thus, providers will have every incentive to perform high-cost procedures and invest in expensive medical technologies because these are likely to be less affected by high-deductible health insurance.

In 2003, California enacted legislation (AB 1528) to create the "California Health Care Quality Improvement and Cost Containment Commission," tasked with developing public policy proposals to control health care costs and enhance quality of care. Although not the bold actions that are needed, establishing and funding the commission called for in AB 1528 could be an important step for California, at least in beginning a public dialogue on these critical issues. There is growing consensus from left and right that developing an integrated electronic medical record system will both improve quality of care and reduce administrative costs. However, it is unlikely to directly constrain the growth in health care costs. One strategy that a cost containment commission should consider is what many European countries have long done—establish an integrated multi-payer system. In a multi-payer system the government imposes global spending limits and organizes payers and providers into a coordinated and uniform system, ideally utilizing an integrated information system for risk-adjustment. Such a system would provide a global mechanism for cost control superior to our current fragmented and uncoordinated payments, while still maintaining a range of insurance product choices that are of paramount importance to the public at large.[40]

38 May JH, Cunningham PJ, *Tough Trade-Offs: Medical Bills, Family Finances and Access to Care*, Issue Brief No. 85, June 2004. See also Costello D, "At What Cost?" *Los Angeles Times*, April 4, 2005.

39 Kaiser Family Foundation, *Trends and Indicators in the Changing Health Care Marketplace*, Chart 1.11, Report #7031, February 2005.

40 Hussy P and Anderson GF. "A Comparison of Single- and Multi-Payer Health Insurance Systems and Options for Reform," *Health Policy and Management*, 66(2003); 215-28. See also: U.S. Congressional Budget Office. *Single-Payer and All-Payer Health Insurance Systems Using Medicare's Payment Rates*. CBO Staff Memorandum. Washington, DC: U.S. Congressional Budget Office, April 1993; U.S. General Accounting Office, *Canadian Health Insurance: Lessons for the United States*. Statement of C. A. Bowsher before the Committee on Government Operations, House of Representatives. Washington, DC: U.S. General Accounting Office, June 1991.

LEVERAGING SUCCESS IN COVERING CHILDREN

California's success in expanding health insurance coverage for its children, even in the face of declining job-based insurance, is due to focused public policies and their effective implementation by many agencies and organizations. The Medi-Cal and Healthy Families programs—both of which generate federal funds to match State expenditures—provide coverage to several million children throughout the year, and they have been made to work more effectively by simplifying administrative eligibility provisions and making them more "family friendly." One of the more important reforms has been making children who qualify for Medi-Cal continuously eligible, a change that Medi-Cal officials estimate enabled about 900,000 children to retain their Medi-Cal coverage due to bureaucratic procedures, thus avoiding adding them to the roles of the uninsured. Recently, local "Healthy Kids" coalitions in more than two dozen counties have brought together county health departments, county-sponsored health plans, First 5 county commissions, advocates and foundations to develop locally sponsored health insurance programs that fill in the gaps left by other public programs. By April 2005, the 11 local Healthy Kids programs that were in full operation covered 75,000 children who do not qualify for Medi-Cal or Healthy Families. All of these efforts were needed to reduce uninsurance among children while access to employment-based insurance was falling.

Many groups and individuals deserve credit for this continuing success:

- Three successive governors have supported the programs.
- Legislators have enacted targeted and thoughtful policies to ensure their effective implementation and did not hesitate to enact "fixes" when problems were brought to their attention.
- The California Department of Health Services, which administers the Medi-Cal program, and the California Managed Risk Medical Insurance Board (MRMIB), which administers the Healthy Families program, provided leadership, collaboration and resources.
- County health departments altered their own bureaucratic cultures to make getting children covered a high priority.
- County First 5 commissions put resources into outreach and enrollment as well as into funding local Healthy Kids programs for very young children.
- A broad range of advocacy groups made covering children an important part of their mission.
- Locally sponsored health plans provided both technical and financial resources to conduct outreach and enroll eligible children.
- Several foundations, particularly The California Endowment, provided key financial support to the outreach and enrollment efforts of advocacy groups and public agencies, and provided leadership and funding for the development of local Healthy Kids programs.

Nevertheless, even the expanded Medi-Cal and Healthy Families programs and local Healthy Kids programs left over 300,000 uninsured children with no coverage option. Other programs have filled in a few of the gaps left by Medi-Cal, Healthy Families and local Healthy Kids programs. The Child Health and Disability Prevention Program (CHDP) has funded screening and limited health care for low-income children not eligible for Medi-Cal and Healthy Families. Some private nonprofit programs, like California Kids and Kaiser Permanente's "KP Cares for Kids," have also helped fill in where federal and state programs combined left groups of low-income children with no coverage options.

Covering all children in California would complete the progress that has been made over the past several years.

This increased children's coverage and enrollment in Medi-Cal and Healthy Families is due to extensive efforts and resources invested in outreach and enrollment—by State and local agencies and voluntary organizations—to reach out to families and enroll eligible uninsured children. It also reflects greater opportunities for retaining already-enrolled children as a result of Medi-Cal's implementation of continuous eligibility. Local Healthy Kids programs have made an important additional contribution, but most of them have now imposed enrollment caps because the numbers of enrolled children have reached the maximum funding available from local financial resources.

A proposal by the 100% Campaign, a children's health insurance advocacy group, and PICO California, a faith-based advocacy coalition, would create a statewide eligibility standard for children's public coverage that matches the standard set by county Healthy Kids programs. The legislation they are sponsoring, Senate Bill 437 (Escutia) and Assembly Bill 772 (Chan), would be a big step toward covering all children in California. According to PricewaterhouseCoopers, it would cost the State up to approximately $300 million a year from the General Fund, assuming nearly complete participation by eligible children, a goal that would be likely to occur only after several years of full implementation. This would be an effective policy to complete the goal of covering all California children that was implicit in the numerous expansions of Medi-Cal and Healthy Families that the State has been undertaking for the past decade.

UNINSURED ADULTS ARE OUT IN THE COLD

Despite the progress in covering children, California has yet to take any significant steps to help the 5.6 million adults who are uninsured find affordable coverage. One small and relatively simple way to start taking serious steps to cover uninsured adults would be to implement the approved, but not-yet-funded, Healthy Families expansion to eligible parents of children who are also eligible or enrolled in Healthy Families, a step that would extend coverage to 377,000 uninsured adults. Beyond this, California needs to take some much bolder steps to address this very large and growing uninsured population.

Three policy strategies attempt to address this issue: 1) a "pay or play" requirement imposed on employers and employees; 2) an individual mandate that would require each California resident to demonstrate that he or she has

coverage; and 3) legislation to consolidate all health care payment sources into a publicly run single-payer health insurance system that would replace private health insurance as we know it.

"Pay or Play" – The Rise and Fall and Possible Resurrection of an Employer Mandate

In 2003, the Legislature passed SB 2, the Health Insurance Act of 2003, a bill authored by Senator John Burton (D-San Francisco), the Senate President; Governor Davis signed SB 2 in October of that year. SB 2 would have required employers to provide health benefits or to pay into a State-administered fund that would contract for mandated coverage. In its first year of implementation, originally scheduled for 2006, employers with 200 or more workers would have had to pay at least 80% of the cost for coverage for the worker and the worker's family. A year later, employers with 50-199 workers would have had to pay for coverage only for their workers. Firms with 20-49 workers would have been required to offer worker-only coverage only if State-provided subsidies were provided to help offset the costs. SB 2 would not have affected employers with fewer than 20 workers.

California's attempt to implement a pay-or-play mandate lost by less than one percent and may have strong political legs as a means to assure health insurance coverage to California workers.

To be eligible under SB 2, an employee must work at least 100 hours a month and be employed by the firm for at least three months. Eligible employees would be required to pay their share of the cost of coverage. The UCLA Center for Health Policy Research estimated that about 860,000 uninsured workers and their dependents would receive health insurance in the first two years of SB 2's implementation, and that a total of 1.1 million would be covered if the small-firm subsidies were also implemented.[41] One of the criticisms of SB 2 was that it imposed significant compensation cost increases per worker on low-wage firms, which might see their labor costs rise significantly as a result of having to pay for their workers' coverage.

Opponents of SB 2 succeeded in putting a repeal initiative on the November 2004 election ballot (Proposition 72). The result was that 50.9% of voters cast their ballots against SB 2, ending this attempt to require employers and employees to obtain coverage. On the other hand, 49.1% of voters supported imposing this requirement. California's attempt to implement a pay-or-play mandate lost by less than one percent and may have strong political legs as a means to assure health insurance coverage to California workers. Some variation of that proposal may reappear in the next year or so.

Individual Coverage Mandate

In 2005 Assemblyman Joe Nation (D-San Rafael) and Assemblyman Keith Richman (R-Granada Hills) introduced the Universal Healthcare Act of 2005. This proposal, AB 1670, would require every individual to maintain at least basic health insurance. Every Californian would be required to provide evidence of coverage by at least a high-deductible health plan (with deductibles up to $5,000) that includes preventive care coverage. Assemblyman Richman and Nation argued that such "basic health care insurance" would "reduce

41 Brown ER, Yu H, Lavarreda SA, Becerra L, Dube A, Kronick R, *SB 2 Will Extend Coverage to 1 Million Uninsured Workers and Dependents*, Health Policy Fact Sheet, Los Angeles: UCLA Center for Health Policy Research, September 2003.

the increasing trend of 'medical bankruptcy,' provide individuals with preventative care, and qualify them for network pricing established by the private sector health plan which reduces the cost of medical visits."

AB 1670 suggested, without a clear source of funding or specified mechanism, that subsidies would be provided to "qualified employers who offer essential benefits coverage for their employees who earn less than 200% of the federal poverty level." (A qualified employer was defined as having less than 50 employees, 60% of whom earn less than 200% of the minimum wage.) Although the intent of this language was clearly to provide the subsidies, it is unclear that such subsidies would actually be available to moderate- and lower-income workers who would need them in order to make such a mandate affordable. The bill was voted down in committee during the 2005 legislative session, but the authors have vowed to resubmit it with revisions during the next session.

AB 1670 has at least one very important policy benefit. Enacting a requirement that all individuals must participate in the health insurance coverage system would establish a critically important element that is needed to achieve coverage of the entire population. Voluntary systems allow individuals or employers to opt out and they therefore cannot achieve universal coverage.

However, AB 1670 also has some significant limitations. First, implementing the individual mandate would require very substantial subsidies from the government to make even catastrophic insurance affordable to low-income individuals and to moderate- and low-income families. In addition to the employer subsidy mentioned in the bill, the authors have suggested their intention to provide additional subsidies directly to the very lowest income Californians. However, it is reasonable to argue that subsidies would actually be needed up to 400% of the federal poverty level (e.g., $60,820 for a family of three) to cover the approximately $3,000 to nearly $7,000 premium cost of family coverage through a high-deductible health plan. At that level, more than 50% of Californians would be receiving subsidies, requiring significant tax increases to pay for it. Such subsidies are needed to reduce the financial burden on moderate-income families that otherwise would pay 5 to 10% or more of their gross incomes for health insurance premiums. But many families in a high-deductible plan still would face significant financial exposure, making them vulnerable to medically-related bankruptcy as well as to tough choices between paying medical bills or paying the rent, paying for utilities and even putting food on the table.

A second limitation is that an individual mandate like the one in AB 1670 would likely have the unintended effect of accelerating the erosion of comprehensive insurance coverage. As health insurance premiums continue to rise, and as employers shift more costs to their workers and cut benefits from comprehensive health plans, AB 1670's reliance on high-deductible health plans would tend to attract lower- and moderate-income persons who perceive themselves as lower risk. This shift in the market will leave a higher-risk population in comprehensive plans, further accelerating their cost increases and making high-deductible heath plans the only relatively affordable choice. The measure would have the predictable effects of shifting many Californians from the ranks of the *un*insured to the ranks of the *under*insured and lead others to replace their higher-premium comprehensive coverage with lower-premium, but high-deductible plans, making them underinsured.

Thus, although AB 1670 is a thoughtful attempt to move the political process toward dramatically reducing the number of uninsured, it would require greater tax-funded subsidies than the bill provides for, and it would increase the financial exposure of more Californians and likely increase the rate of medically related personal bankruptcies.

Moving to a Single-Payer Health Care System

The third alternative is to replace the fragmented private health insurance system with a publicly run "single-payer" health care system that would provide coverage to all Californians. Long a goal of many health advocates, single-payer proposals have been repeatedly introduced in the California Legislature, including proposals by Republican Governor Earl Warren in the 1940s and more recent proposals sponsored by Health Access, a consumer advocacy group.[42] In the last several years, Senator Sheila Kuehl (D-Santa Monica) has been the author of the current single-payer bill, SB 840 (in the previous legislative session: SB 921). Under SB 840, taxes would replace all deductibles and premiums, and the government would become the soul payer of all health insurance benefits. Employers and employees would pay more progressive taxes to a State trust fund rather than premiums to health insurance companies. The bill also shifts reimbursement for hospitals and other providers back to fee-for-service, which would provide relief on the supply side of the health care system.[43] There is considerable evidence that Senator Kuehl's proposal would dramatically reduce the high administrative costs of the current system and that the enormous purchasing power of such a state program would enable it to reduce the costs of prescription drugs and medical devices. [44]

There are many features of a single-payer system that are attractive to health policy analysts as well as to the advocates. First, a universal single-payer system would sever the dependence of health insurance on employment. As workers change or lose jobs, their health insurance coverage and that of their family would not be affected. Second, a single-payer system would facilitate more effective cost control. As noted above, a unified single insurance plan would reduce the high administrative costs associated with the current churning and changing of coverage, as well as the myriad payment rates and systems that are expensive to administer for providers of care and for payers alike. By consolidating the purchasing power of all residents in the state, such a plan also could exert greater control over both the prices that health care suppliers charge and the rate of growth in health care costs. Third, having a single source of health care financing would effectively address the problems that patients and health care providers face with currently fragmented sources of coverage. It would reduce the frequent confusion that individuals and families face about what is covered and what is not, what providers they can use and which ones they cannot use.

Nevertheless, a single-payer system has its critics, and a number of serious criticisms have been leveled against it. Just as markets can fail, so can government. According to Charles Wolf, government faces a number of challenges, including the fact that it is, by nature, monopolistic and does not have to adhere to bottom-line profit and loss signals.

42 Mitchell DJB, "Impeding Earl Warren: California's Health Insurance Plan that Wasn't and What Might Have Been," *Journal of Health Politics, Policy and Law* 2002; 27(6): 947-976.

43 Text of SB 840, *www.legislature.ca.gov*, accessed on 5/25/05.

44 Sheils JF and Haught RA, *The Health Care for All Californians Act: Cost and Economic Impacts Analysis*, Prepared for Health Care for All Education Fund, January 2005: The Lewin Group.

Government agencies are overseen by politicians who are more likely to look for quick fixes than for long-term solutions.[45] This means that the public policies developed may fail to achieve all of the goals of efficiency and equity associated with single-payer—although such a system would almost certainly be more efficient and equitable than the current market-dominated one. Public control creates the conditions for more accountability to the public's interests, but the controlling executive and legislative branches of government are subject to political influence that can constrain the efficiency and effectiveness of a public agency, often on behalf of the special interests that deal with the subordinate government agency.

The political challenges are equally formidable. Even though many researchers have shown that single-payer systems can save money, this is a difficult sell to the public, particularly in the U.S. where interest groups are largely responsible for the funding of political campaigns. Perhaps the main hurdle is the fact that even if total health care expenditures would be lower under a single-payer system, *government* expenditures—and therefore, taxes—would be higher since the vast majority of health spending would be from the public sector. It has proven difficult to successfully persuade the public that they might spend less overall because their higher taxes could be more than offset by larger take-home wages when employers no longer have to pay the additional fringe benefits associated with employer-based health insurance. Indeed, this was the experience in California in 1994 when Proposition 186, a single-payer initiative, was rejected by nearly three-quarters of the electorate.

45 Wolf C., "A Theory of Nonmarket Failure: Framework for Implementation Analysis," *Journal of Law and Economics* 1979; 22: 107-39; Wolf C., *Markets or Governments: Choosing Between Imperfect Alternatives.* Cambridge, MA: MIT Press, 1993.

Bold steps are needed to effectively control the growth in health care costs for all income groups.

IN CONCLUSION

Bold steps are needed to effectively control the growth in health care costs for all income groups, thus avoiding the potential consequence of bare-bones insurance coverage that is likely to increase the burden of medical care costs on moderate- and lower-income families and individuals, and reduce their access to necessary medical care. Most other economically developed nations have more effectively and equitably controlled the growth in their health care spending, most through some combination of "all-payer" or "single-payer" management of paying for health care. Until the United States, as a whole, or California, in a leadership role, adopts effective controls over the health care spending, we can expect to see a continuing, and even accelerating, erosion of employment-based insurance.

There are some valuable immediate and longer-term steps that California can take to cover the uninsured. Expanding coverage for children represents the relatively low-hanging fruit because it is relatively modest and builds on the longstanding commitment of State and Federal policy makers—and the public—to assure health insurance and access to care for all children. Additional measures that would cover adults are more challenging, both fiscally and politically. Nevertheless, bold leadership will be needed to address this widespread, serious and growing problem. The dialogue created by pay-or-play, the proposal for an individual mandate, and the proposed single-payer system offer an opportunity to engage the public in a fruitful discussion and begin building a political consensus on the direction that California should take to cover all of its residents.

APPENDIX. ESTIMATING UNINSURANCE USING POPULATION-BASED SURVEY DATA

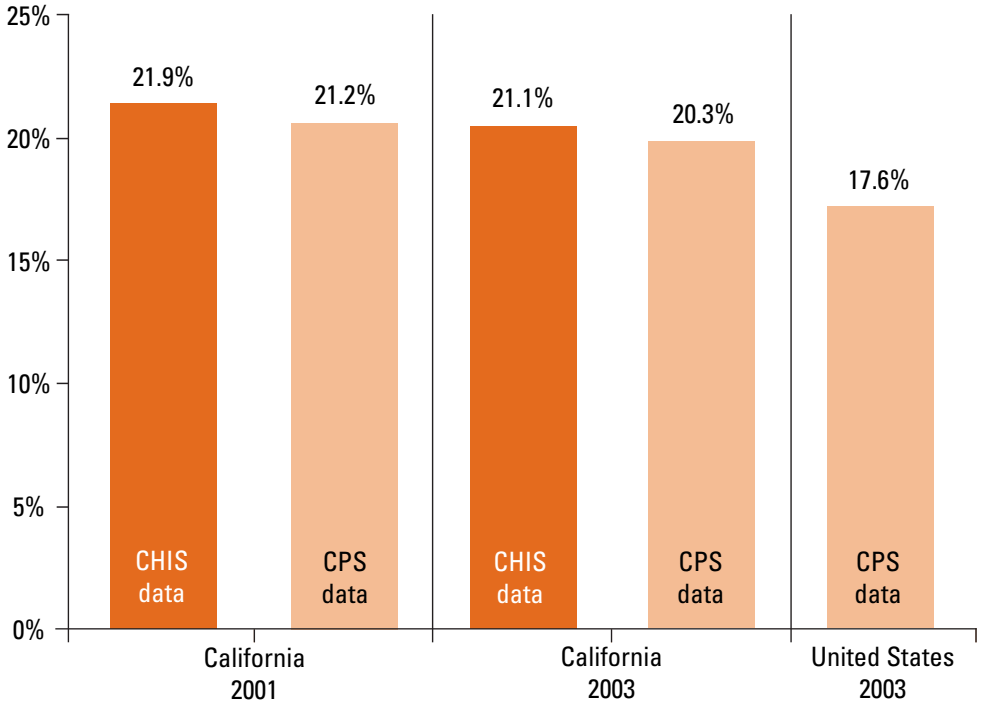
appendix

This report is based on data from the California Health Interview Survey (CHIS), conducted by the UCLA Center for Health Policy Research in collaboration with the California Department of Health Services and the Public Health Institute. In this Appendix, we describe the survey and discuss the relationship of its estimates to another widely-cited source of data on health insurance coverage, the Current Population Survey (CPS).

CHIS AND THE CURRENT POPULATION SURVEY

CPS, conducted by the U.S. Census Bureau, is the data source previously used by the UCLA Center for Health Policy Research for its annual reports on health insurance coverage—and the lack of it—in California. The Center now uses data from CHIS, which features a much larger California sample and state-of-the-art questions on health insurance coverage. CHIS and CPS generate seemingly similar estimates of uninsurance despite fundamental differences in the way these instruments measure health insurance coverage. CHIS

EXHIBIT 41: CALIFORNIA AND NATIONAL RATES OF UNINSURANCE, 2001 TO 2003



Note: Note: CHIS estimates are for persons uninsured for all or part of the year; CPS estimates are for persons uninsured all year.

Source: 2001-R and 2003 California Health Interview Surveys, and March 2002 and 2004 Current Population Surveys

and CPS estimates of uninsurance for both 2001 and 2003 differ by less than one percentage point (Exhibit 41). [46]

The CHIS instrument asks numerous questions about health insurance in the context of an extensive range of health topics, and after a series of questions on the use of health care services. Asking about health insurance coverage after a series of questions on health status, health conditions and use of health services has the effect of improving respondent recall about health care coverage. In contrast, CPS focuses primarily on labor force issues and income, and it asks a short series of questions about health insurance toward the end of the interview.

In addition, CHIS asks respondents questions about their health insurance coverage—lack of coverage at the time of the interview—and an additional set of questions that focuses on health insurance coverage and uninsurance during the preceding 12 months. These two timeframes yield two separate measures of uninsurance: a point-in-time estimate (uninsured at the time of the survey), and an estimate of uninsurance during the previous year (at the time of the survey and during the 12 months before that). It also allows an estimate of the number of persons who experienced any episode of uninsurance during the 12 months prior to the interview. As a result, the March CPS yields a single estimate of uninsurance derived from a few questions asking respondents about coverage at *any time* during the preceding calendar year. The resulting estimate of uninsurance ostensibly reflects lack of coverage throughout the entire year. Health services researchers disagree about whether the CPS estimate truly reflects a lack of insurance from January to December of the previous year, or more closely reflects a point in time estimate,[47] but the *prima facie* interpretation of CPS-based estimates of health insurance coverage and uninsurance should be for the calendar year before the survey year (that is, estimates for 2001 would be made from the March 2002 CPS).

The CHIS 2003 estimate for the number of nonelderly Californians who were uninsured all year is 3,172,000; the estimate drawn from the March 2004 CPS is 6,418,000. Virtually all surveys of health insurance coverage conducted by states result in estimates of uninsurance that are lower than estimates for the same duration of time based on CPS data.

It is clear, however, that March CPS estimates and CHIS estimates measure insurance coverage in different ways and for different time periods. These differences in measurement of coverage make the similarity of the total number of uninsured—CHIS's 6.6 million uninsured for all or part of the year compared to CPS's 6.4 million uninsured all year (Exhibit 41)—largely a coincidence.

46 The CHIS 2001 estimate of the number of uninsured Californians reported here represents a revised estimate using new weights based on California Department of Finance (DOF) data. Some previous publications reported CHIS 2001 estimates using weights based on 2000 Census data. The CHIS 2001 data was reweighted in order to make it comparable to the CHIS 2003 estimates.

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

MEASURING MEDICAID COVERAGE

The extensive set of health insurance questions in CHIS was designed specifically to reduce underreporting of health insurance coverage, especially in the state's Medicaid program (called Medi-Cal in California). Underreporting of Medicaid or other health insurance coverage can inflate estimates of uninsurance, and is of concern among policy experts. All population-based surveys across the country, including CPS, underestimate coverage by Medicaid when those estimates are compared to enrollment numbers from Medicaid administrative data. This undercount is due in part to the limited questions asked about Medicaid and other health insurance coverage. CHIS questions, however, achieve a higher estimate for Medi-Cal coverage, a separate estimate for the Healthy Families Program, a higher total estimate for coverage through public programs, and a slightly lower estimate of employment-based health insurance coverage as compared to CPS.

Medi-Cal administrative enrollment counts for the time period that CHIS 2003 was in the field are very close to CHIS 2003 estimates of Medi-Cal enrollment for persons aged 0 to 64; that is, they fell within the 95% confidence interval of the CHIS estimate. However, estimates of Medi-Cal enrollment and administrative enrollment counts serve different purposes and to some degree measure different things. Health services researchers argue as to whether these numbers are actually comparable. Administrative enrollment counts primarily serve a fiscal purpose, allowing administrators to track and project costs, to identify which claims and capitation rates should be paid, and to draw down a federal match. Survey estimates of Medi-Cal enrollment measure an individual's perception of their enrollment status, which may have implications for their ability to access care.

Medi-Cal is not one single insurance program, but rather a group of programs (defined by eligibility aid codes) that vary widely in the range of benefits provided. Some Medi-Cal programs offer full-scope coverage with no cost sharing. Other Medi-Cal programs provide limited benefits, such as emergency services only, pregnancy-related services only, or no benefit unless the enrollee meets their monthly share-of-cost.[48] While administrative data contains specific information about which type of Medi-Cal coverage an enrollee has, survey questions are less specific and do not differentiate among Medi-Cal programs. Thus, a respondent who has emergency Medi-Cal only may report having Medi-Cal in a survey although they are not, in fact, fully insured. Alternatively, they may not report having Medi-Cal because they were enrolled while hospitalized and are unaware that they have limited coverage from the program for a period of time following hospitalization. Survey researchers must decide to

48 An applicant whose family income exceeds the Medi-Cal income-eligibility limit may qualify for Medi-Cal with a share-of-cost. Each month, they receive no benefit until they have spent on medical care the difference between their household income and the Medi-Cal income-eligibility limits.

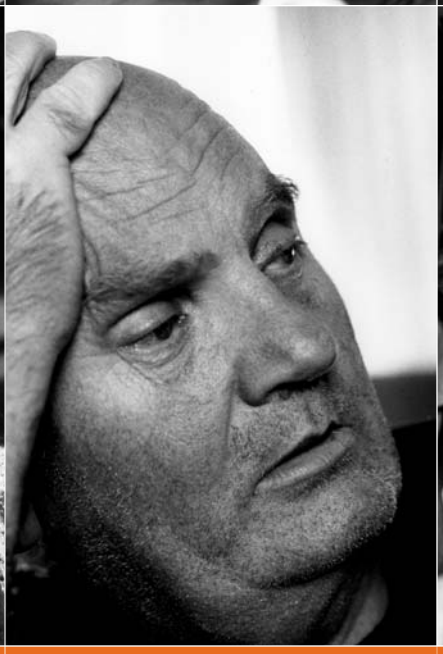
exclude certain Medi-Cal programs from administrative enrollment counts based on whether they believe a survey respondent who is enrolled in a program is likely to report having Medi-Cal. The administrative count used for comparison with CHIS 2003 enrollment estimates excludes people with partial-scope Medi-Cal and Medi-Cal with a share-of-cost.

Research is underway to better inform the development of administrative Medi-Cal enrollment counts used to benchmark enrollment estimates derived from population-based survey data. Researchers at the UCLA Center for Health Policy Research—in collaboration with researchers at the University of Minnesota—are working on three separate studies to better understand how Medi-Cal enrollees answer survey questions on health insurance in order to improve the comparability of administrative enrollment counts used for benchmarking. Results from these studies will be published on our Web site at *www.healthpolicy.ucla.edu*.

Survey estimates paint with a broad brush, providing us with a picture of the social landscape. Population-based surveys, such as CHIS, continue to be the only source of estimates for both the number of Californians who lack insurance, and the number who are eligible for public insurance programs, yet remain uninsured.





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