



# DECLINING JOB-BASED HEALTH COVERAGE IN THE UNITED STATES AND CALIFORNIA: A CRISIS FOR WORKING FAMILIES

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## EXECUTIVE SUMMARY

### 1. Introduction

In the second half of the twentieth century the American system of health care delivery emerged as a dual system of private, employer-sponsored health care for most people, supplemented by public health care for the poor and elderly. Today, rising health insurance premiums, shifting industrial composition and increased use of temporary and part-time workers are leading to a marked shift in the nature of health care coverage for American workers.

This study analyzes how health insurance coverage responded to rising premium costs between 2000 and 2004. We first report coverage trends for individuals and families in different income levels and demographic categories. We then create a statistical model to predict the impact of a given rise in premiums on employer-based coverage, the uninsurance rate and public coverage in the United States. We use data on premium prices over the past five years along with household data to estimate how different types of coverage respond to increases in premium prices for a variety of family types.<sup>1</sup> Finally, using this model we predict the effect of an increase in premiums on employer-based coverage, the uninsurance rate, private coverage and public coverage in the United States and California over the next six years.

The study projects a continued decline in employer-based coverage with the greatest concentration among lower-and-middle income families. This will largely translate into increased uninsurance for adults, and greater take-up of public coverage for children.

### 2. Health Coverage Trends

- Job-based coverage declined from 67% to 63% for non-elderly Americans between 2000 and 2004. Overall, employer-based health insurance coverage for private sector workers declined from 72% in 1979 to 61% in 2004. As a whole, health insurance coverage fell by 2 percentage points. The changes were similar for California.
- Lower- and-middle income families experienced the greatest drop in job-based and overall coverage.
- Public coverage increased, especially for children, partly offsetting the decline in employer-based coverage. During this time period, 3.5 million more children were enrolled in either Medicaid or the State Children's Health Insurance Program (SCHIP) nationally, and public coverage for children rose from 19% to 25% in the United States as whole and from 24% to 29% in California.<sup>2</sup> The increase in public coverage markedly reduced the racial and ethnic disparity gaps in children's coverage.

### 3. Rising Health Care Premiums

- Health care premiums rose sharply between 2000 and 2004 in the United States, registering an 11% annual rate of growth for family plans.
- Employers raised employee contributions toward health care premiums at an even faster rate. Workers' share of premium costs

for family plans rose from 25% to 32% in the United States in this period.

- Rising health premium costs were the principle cause for the coverage decline

#### **4. The Effect of Increasing Premiums on Coverage Rates.**

- Rising premium costs translate into decreases in job-based coverage for working adults, higher rates of public coverage and a higher rate of uninsurance.

At the current U.S. population level and demographic and job characteristics, every 10% increase in health insurance premium means 1.4 million less working family members—910,000 adults and 442,000 children—are insured at the job. Most adults losing job-based coverage become uninsured (654,000). Most children move to public coverage (217,000). Overall, this translates into 817,000 more uninsured individuals and 380,000 more enrollees in public plans.

- Low-to-middle-income individuals, particularly those with incomes between 100% and 400% of the Federal Poverty Level (FPL), experience the greatest reduction in job-based health coverage.

Job-based coverage for working adults between 100% and 400% of FPL responds to price increases at a rate three times as fast as those above 400% of FPL. (For a family of three, 400% of FPL translates to an income of \$59,300.) Working adults below 100%, experience less of a decline because few of these workers have job-based insurance to begin with.<sup>3</sup>

#### **5. Predicted Effects of Increasing Premiums on National Coverage Rates, 2004-2010**

Controlling for population growth, job and demographic characteristics, and differences in public eligibility coverage in different states, we estimate the impact of higher premiums on U.S. families over the next six years. Using 2004 cost data, we estimate the

effect of a 10% annual premium increase for the next six years on employer-based coverage, private coverage, public coverage and the uninsurance rate of the state's non-elderly population.

- If premium rates continue to increase 10% annually over the next six years, the number of non-elderly Americans with job-based insurance will fall below 60% and the number of uninsured will grow to nearly 20% of the non-elderly population.

Job-based coverage will fall from 63% to 59% for all non-elderly Americans. Public coverage will increase from 12% to 14%, while uninsurance rates will increase from 17% to 19%.

- For families in the bottom half of the income spectrum (with incomes below 300% of FPL), the extent of job-based health insurance will drop below 40%, while uninsurance will rise to 30%.
- For children in families below 300% of FPL, the public system is predicted to overtake job-based coverage by 2010, covering 45% and 34%, respectively. The two systems each covered 41% of children in these families in 2004.
- Employer-based coverage will decline at all income levels, but the greatest drops will occur at low and middle incomes.

For the 44% of the nation's population with incomes between 100% and 400% of FPL, job-based coverage declines at twice the rate as those with incomes above 400% FPL. Nationally, 76% of those who are newly uninsured from 2004 to 2010 will be in the low- and middle-income groups represented by the 100% to 400% FPL categories, although this group accounted for only 53% of the uninsured and 44% of the population in 2004.

- By 2010, 7.7 million more Americans will be uninsured and 5.6 million more will be enrolled in a public program.



## 6. Predicted Effects of Increasing Premiums on Coverage Rates in California 2004-2010

To estimate the impact of higher premiums on California families over the next five years, we adjusted the statistical model to the state's demographics and public coverage eligibility levels. Using 2004 cost data, we estimated the effect of a 10% annual premium increase for the next five years on employer-based coverage, private coverage, public coverage and the uninsurance rate of the state's non-elderly population.

- If premium rates continue to increase 10% annually over the next five years, only a bare majority of non-elderly Californians will have job-based coverage, falling from 57% in 2004 to 52% in 2010.
- For California families in the lower half of the income spectrum, twice as many individuals will be either uninsured or on public coverage as will have employer-sponsored coverage. The number of uninsured will be greater than the number of individuals with job-based health insurance.

For half of the state's individuals in families with incomes below 300% of FPL, public coverage will rise from 26% to 29% and uninsurance from 31% to 34%, while job-based coverage will drop from 35% to 29%.

- For adult Californians in families with incomes below 300% of FPL, by 2010, the proportion of uninsured (42%) will eclipse the proportion covered at the job (30%). These two proportions were equal in 2002.

Children in families with incomes below 300% of FPL will see a drop in job-based coverage from 34% to 27% and a continuing increase in public coverage from 46% to 51%, while uninsurance will rise back to 19% from 17% in light of ongoing reduction in employer-sponsored insurance.

- Employer-based coverage is predicted to decline across all income levels, but the greatest drops

will occur at low-to-middle income levels.

For the 44% of the state's population with incomes between 100% and 400% of FPL, job-based coverage declines at twice the rate as those with incomes above 400% FPL

- By 2010, taking population growth into account, 1.5 million more will be uninsured and 880,000 more will be enrolled in a public program as compared to 2004.

## 7. Implications

Employer-based health coverage has eroded significantly over the past five years. Without immediate action, job-based health coverage will continue to deteriorate, with the greatest impact on low and middle-income families. If premium costs continue to rise near current levels, by 2010, only a slight majority of non-elderly individuals in California will have coverage through an employer. For families under 300% of FPL, more Californians will be uninsured than have job-based coverage by the end of the decade.

What used to be a fundamental component of the social contract for American workers across the income spectrum is rapidly becoming a benefit enjoyed primarily by higher-income employees. Should premiums continue to rise at or near current rates, the erosion of employer-based coverage will begin to affect even that higher income category.

Since those losing job-coverage are disproportionately in low- and middle-income families, purchasing individual insurance plans at market rate is not an affordable option. Private coverage rates for low- and middle-income families are projected to remain steady over the next five years even as employer-sponsored insurance declines. Therefore policies that rely on private insurance, such as individual mandates are mismatched to the realities of those losing insurance today. Similarly, the contributions needed for health savings accounts to have a meaningful insurance value would be prohibitive for individuals in these income ranges.

Corresponding to the drop in employer-based coverage is an increase in public coverage. As more workers lose access or are unable to afford their rising share of costs, they either enroll in a public program (if eligible) or become uninsured. By 2010, the number of individuals below 300% of FPL with public coverage will be slightly below the number with job-based insurance. This reflects a significant cost shift for health care from the private sector to state and local government. In 2002, half of California spending on Medi-Cal and Healthy Families (SCHIP) went to working families (Zabin, Dube 2004).<sup>4</sup>

Until now, Medicaid and SCHIP have largely, though not entirely, buffered lower income families from the decrease in job-based coverage. States with more gen-

erous eligibility rules have seen a smaller increase in uninsurance than those with less generous policies. But unless immediate measures are taken to control costs and stem the fall in job-based coverage, significant new funding will be needed to absorb the growing numbers of people without employer-sponsored insurance. Higher eligibility levels will also be needed to avoid greater uninsurance. Yet in response to rising expenditures, both the state and federal governments are implementing new cost-cutting mechanisms that would limit enrollment and reduce services. If the combination of declining employer-based coverage, more restrictions on public programs, and greater costs to consumers continues, we will likely see an explosion in the number of uninsured.

**INTRODUCTION:** In the second half of the twentieth century, the American system of health care delivery emerged as a dual system of private, employer-sponsored health care for most people, supplemented by public health care for the poor and elderly. However, changes in the health insurance industry over the last few years indicate an imminent and fundamental shift in the nature of health care coverage for the American worker. Job-based health coverage is eroding for working families due to rapidly rising premium costs, changing patterns of job growth and increased use of temporary and part-time workers. As a result, greater numbers of working families are relying on public health programs for care.

This study evaluates how employers have responded to the recent sharp increase in health insurance premiums and the subsequent effect on various segments of the population. It is divided into three sections. The first section uses household data from the Current Population Survey (CPS) to report changes in health care coverage for adults and children from 2000 to 2004. Changes in rates are reported for overall coverage, job-based coverage, private coverage and public coverage by income and demographic characteristics for both the United States and California. In the second part, we augment this

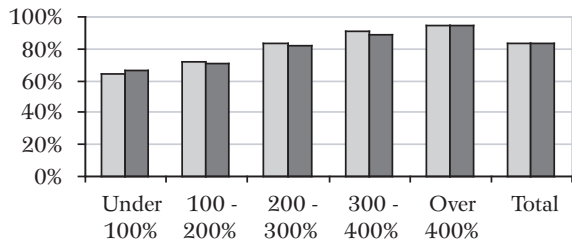
data with premium price information from the same period to estimate how a given increase in premium costs impacts coverage rates using a regression model. The analysis controls for factors including changes in job compositions, demographic changes, and public health plan eligibility rules. Finally, we simulate premium price increases using the regression model and California-specific factors to predict changes in state-level and national coverage by employers, privately purchased plans, public plans and uninsured rates over the next five years.

## HEALTH COVERAGE AND PREMIUM COST TRENDS 2000-2004

Structural changes in the health insurance system during the last four years suggest that a shift is occurring in the way individuals and families obtain health coverage. Access to health insurance has declined, particularly among individuals and families who are covered through their employer. This trend has led to a rise in public coverage enrollment as well as in the uninsured population. Furthermore,

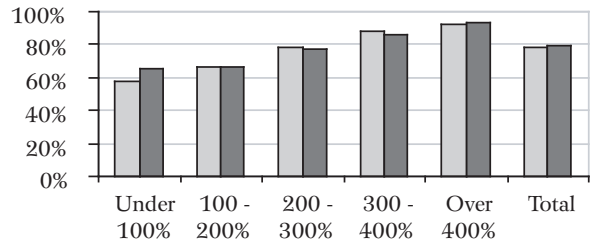
workers, employers and the government have experienced record increases in the cost of health coverage. The following section will discuss trends in coverage and cost premiums in the United States and California between 2000 and 2004. Special attention will be paid to trends among adults and children in different income groups.

**CHART 1: INSURANCE COVERAGE FOR ALL U.S. NON-ELDERLY**



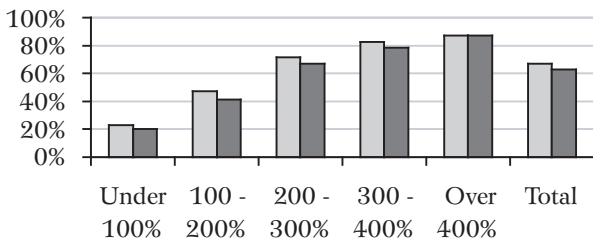
SOURCE: MARCH CURRENT POPULATION SURVEY 2000-2004

**CHART 2: INSURANCE COVERAGE FOR ALL NON-ELDERLY IN CALIFORNIA**



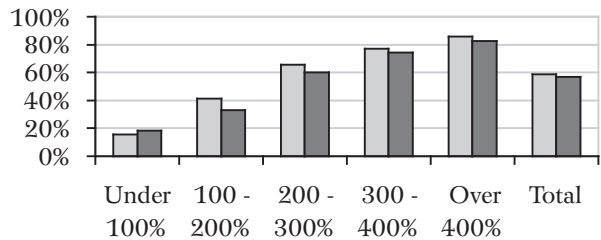
SOURCE: MARCH CURRENT POPULATION SURVEY 2000-2004

**CHART 3: JOB-BASED COVERAGE FOR ALL U.S. NON-ELDERLY**



SOURCE: MARCH CURRENT POPULATION SURVEY 2000-2004

**CHART 4: JOB-BASED COVERAGE FOR ALL NON-ELDERLY IN CALIFORNIA**



SOURCE: MARCH CURRENT POPULATION SURVEY 2000-2004

■ 2000 ■ 2004

The data in this section is from the March Supplement to the household-based Current Population Survey. Findings include trends in health coverage, employer-based coverage and enrollment in public insurance programs. Coverage is measured by looking at children (under 19) and non-elderly adults (ages 19-65).<sup>1</sup>

### A. Health Coverage Trends, 2000-2004

On average, health care coverage for all individuals under the age of 65 declined slightly in the United States between 2000 and 2004, and increased minimally in California. Nationally, health insurance coverage decreased by one percentage point to 81% and rose one percentage point in California to 80% (Charts 1 and 2 on page 14). Although not shown in the following table, California's increase is characterized by a jump in the coverage rate between 2000 and 2001, and stability in the following years.

The primary cause for these fluctuations is the decrease in the number of workers who receive health benefits through their employer. Nationwide, between 2000 and 2004 job-based coverage waned from 67% to 63% for all individuals under the age of 65 (Chart 3 on page 10). To put this in context, own-employer-based health insurance coverage for private sector workers declined from 72% in 1979 to 61% in 2004. California's employer-based coverage rates, which already have rates below the national average, also

declined (Chart 4 on page 10). Only 57% or roughly 18 million people, received health insurance through their employer in 2004, down from 59% in 2000.

While this trend is not dramatic in the aggregate, the erosion of job-based health care coverage has significantly affected certain specific populations. Lower-income and middle-income individuals and families experienced the biggest drop in employer-sponsored coverage. Nationally the greatest rate of decline was among individuals between 100% and 200% of FPL, which includes 43.5 million people or 17.5% of our nation's population (Tables 1 and 2). Among this group job-based coverage fell from 47% to 41%. In California, only 33% of roughly 6 million individuals in this same income bracket received coverage through their employer, down from 41% in 2000. Individuals between 200% and 300% of FPL also experienced a drop, down four percentage points nationally and five percentage points in California. By 2004, 3.6 million fewer workers in the U.S. below 300% of FPL had employer-based health coverage and 4 million more were uninsured as compared to 2000. In California during the same time period, 538,000 fewer workers below 300% of FPL had coverage through their employer and 162,000 more were uninsured. Median income for California families is 283% of the FPL (Table 1 and 2).

**TABLE 1: FEDERAL POVERTY INCOME LEVELS**

Year	Number of Adults	Number of Children	Income at 100% of FPL	Income at 300% of FPL
2000	1	0	\$8,959	\$26,877
2000	1	1	\$11,869	\$35,607
2000	1	2	\$13,874	\$41,622
2000	2	2	\$17,463	\$52,389
2000	2	3	\$20,550	\$61,650
2004	1	0	\$9,827	\$29,481
2004	1	1	\$12,971	\$38,913
2004	1	2	\$15,219	\$45,657
2004	2	2	\$19,157	\$57,471
2004	2	3	\$22,543	\$67,629

SOURCE: CENSUS BUREAU

**TABLE 2: PERCENT OF INDIVIDUALS AT OR BELOW 300% OF FPL**

Year	California	United States
2000	53.4%	50.3%
2001	52.9%	49.2%
2002	54.2%	49.9%
2003	52.6%	50.3%
2004	52.0%	50.6%

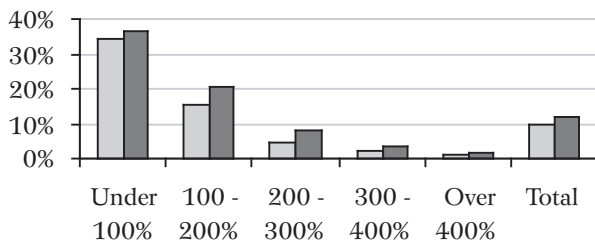
SOURCE: CENSUS BUREAU

**TABLE 3: INSURANCE COVERAGE FOR ALL NON-ELDERLY**

Federal Poverty Level	United States			California		
	2000	2004	Change 2000-2004	2000	2004	Change 2000-2004
<b>Overall Health Coverage</b>						
Less than 100%	63.1%	63.3%	0.1%	57.9%	64.8%	6.9%
100%-200%	70.5%	68.4%	-2.0%	65.8%	66.5%	0.7%
200%-300%	83.2%	81.0%	-2.2%	78.8%	76.9%	-1.9%
300%-400%	90.4%	87.6%	-2.8%	87.6%	85.9%	-1.8%
400% and Above	93.9%	93.4%	-0.5%	92.5%	93.5%	1.0%
<b>Total</b>	<b>82.5%</b>	<b>81.1%</b>	<b>-1.5%</b>	<b>77.9%</b>	<b>79.8%</b>	<b>1.8%</b>
<b>Employer-Based Coverage</b>						
Less than 100%	22.4%	20.2%	-2.1%	16.4%	18.1%	1.7%
100%-200%	47.5%	41.0%	-6.4%	41.2%	32.5%	-8.7%
200%-300%	71.4%	66.8%	-4.6%	65.1%	59.7%	-5.4%
300%-400%	82.6%	78.7%	-3.9%	77.5%	74.7%	-2.8%
400% and Above	87.6%	86.5%	-1.1%	85.0%	83.2%	-1.8%
<b>Total</b>	<b>66.7%</b>	<b>62.9%</b>	<b>-3.8%</b>	<b>59.2%</b>	<b>56.9%</b>	<b>-2.3%</b>
<b>Public Coverage</b>						
Less than 100%	34.2%	36.5%	2.3%	36.0%	38.2%	2.2%
100%-200%	15.7%	20.8%	5.1%	19.6%	25.5%	5.9%
200%-300%	4.8%	8.1%	3.3%	4.8%	9.6%	4.8%
300%-400%	2.4%	3.3%	0.9%	4.3%	4.2%	-0.1%
400% and Above	1.1%	1.5%	0.4%	1.4%	1.5%	0.1%
<b>Total</b>	<b>9.8%</b>	<b>12.2%</b>	<b>2.4%</b>	<b>12.6%</b>	<b>14.5%</b>	<b>1.9%</b>

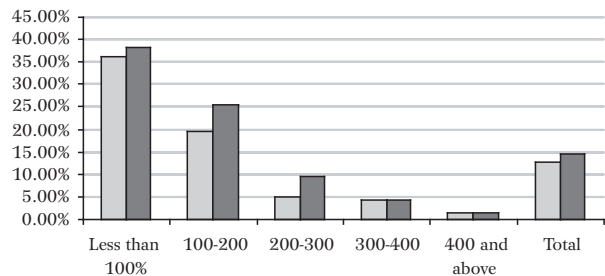
SOURCE: MARCH CURRENT POPULATION SURVEY 2000-2004

**CHART 5: PUBLIC COVERAGE FOR ALL U.S. NON-ELDERLY**



SOURCE: MARCH CURRENT POPULATION SURVEY 2000-2004

**CHART 6: PUBLIC COVERAGE FOR ALL NON-ELDERLY IN CALIFORNIA**



SOURCE: MARCH CURRENT POPULATION SURVEY 2000-2004

■ 2000 ■ 2004

In contrast, people at or above 400% of FPL experienced much more muted drop-offs two percentage points in California and one percentage point for the country as a whole. By 2004, 87% of US workers earning incomes above 400% of FPL received health insurance through their employer, compared to 20% of workers below 100% of FPL and 41% of workers between 100% and 200% of FPL. Although there was a substantial difference in employer-based coverage between these workers in 2000, by 2004 the gap had widened. This data shows the dramatic manner in which changes in health coverage have affected individuals and families differently at various income levels (Table 3).

In tandem with the noticeable slide in employer-based coverage, enrollment in public health programs rose substantially. Nationally, public coverage for all non-

elderly people increased from 10% in 2000 to 12% in 2004 and from 13% to 15% in California (Chart 5 and 6). This jump in public coverage helped offset the lower rate of employer-based insurance among lower-income families, particularly children. Again, the aggregate numbers fail to capture what is going on with specific populations.

The health coverage dynamics for adults and children have been substantially different. Both populations experienced erosion in employer-based coverage; however children have benefited greatly by enrolling in public programs, a resource to which few adults can gain access. Low-income children accounted for a large percentage of the rise in public coverage, while adult enrollment grew very little resulting in an increase in uninsurance among adults.

## PUBLIC HEALTH INSURANCE PROGRAMS

Medicaid and the State Children's Health Insurance Program are the nation's largest public health insurance programs that provide comprehensive medical coverage to children, low-income adults, elderly and disabled. Medicaid (Medi-Cal in California), which began in 1965, is jointly funded by state and federal governments and provides comprehensive health care services to more than 19 million children, 10 million low-income adults and 12 million elderly and disabled nationwide. In California, approximately 6.3 million are enrolled in Medi-Cal, half of whom are children. Eligibility levels for Medicaid vary substantially by state, ranging from 100% of FPL to 300% of FPL. In California, children up to 133% of FPL and parents up to 107% of FPL are eligible for Medi-Cal. The State Children's Health Insurance Program (SCHIP) was created to build on Medicaid program and provide health insurance to children who cannot gain access to employer-based coverage and who are ineligible for Medicaid. Since its creation in 1997, virtually every state has taken steps to extend health coverage to low-income children (and in some states to parents), and by 2003 more than 7.1 million individuals were enrolled in SCHIP. Eligibility for SCHIP also varies by state; in California children up to 250% of FPL are eligible for either Medi-Cal or SCHIP.

In addition to SCHIP and Medicaid, other local and state programs have been created or expanded to further improve access to health insurance for children who are not eligible for an existing public program. In California, the Children's Health Initiative, which first began in 2001 in Santa Clara County and has now includes ten other counties, provides coverage to all children below 300% of FPL. Other states, such as Maine and Illinois, are currently working toward statewide efforts that

would further expand coverage to children and uninsured adults.

Finally, uninsured individuals who do not qualify for a public health program often rely on the local safety net institutions for basic health care services. In California alone, hospitals and other safety net providers spend an estimated \$3 billion annually in caring for the uninsured.

**B. Health Trends by Gender, Ethnicity and Education Level**

At the national level the fall in job-based coverage for adults was similar across ethnicity nationwide. Job-based coverage fell three percentage points for Latinos, African Americans and whites and was unchanged for Asians. However, both Latinos and African Americans continue to receive significantly lower rates of employer-based health coverage - 50% for African Americans and 41% for Latinos, compared to 69% for Whites and 63% for Asians. In California, job-based coverage dropped most sharply among African Americans (eight percentage points), compared to a two-percentage point drop for whites. There was a minimal increase in employer-based coverage for Latinos in California, however they continue to have the lowest rate of job-based coverage at 42%. The fall in job-based coverage among African Americans was offset by an increase in public coverage (Table 4).

Job-based coverage for men fell more sharply than coverage for women nationally and in California, eliminating the gender gap in employer-based coverage. Women continue to have higher overall coverage rates than men in both California and nationally. When looking at education levels, adults with no college degree experienced a slightly steeper decline in employer-based coverage compared to their college-educated counterparts and continue to have a 14-percentage point overall coverage differential, as job-based coverage for U.S. adults without a college degree dropped from 63% to 58% compared to a drop from 83% to 80% for college-educated adults. In

California, employer-based coverage fell from 55% to 51% for adults with no college degree and from 78% to 75% for those with a college degree (Table 4).

**C. Health Trends for Working Families**

Even if we factor out those who do not belong to full-time working families, health care coverage has declined since 2004. Our definition of a “family” corresponds to the concept of a health insurance eligibility unit. It is composed of adults, their spouses, all children under 18, and children between the ages of 19-23 if they are full-time students. A “full-time working family” is defined as a family having at least one member working at the time of the interview, who works at least 35 hours a week and has worked at least 45 weeks in the past year.

Table 5 (on page 16) reports that between 2000 and 2004, health coverage for working families in the United States declined one percentage point to 86% and employer-based coverage fell three percentage points to 76%. The steepest declines in employer-based coverage were among low-to-middle-income families at or below 300% of FPL, who experienced declines from four to six-and-a-half percentage points, down to 25% for families below 100% of FPL, 49% for families between 100% and 200% of FPL and 72% for families between 200% and 300% of FPL. Public coverage for these families helped offset the substantial drop in employer coverage. Nationally, enrollment climbed by five percentage points to cover 33% of families below 100% of FPL, and by six percentage points to insure 18% of families between 100% and 200% of FPL.



**TABLE 4: INSURANCE COVERAGE FOR ALL NON-ELDERLY BY GENDER, ETHNICITY, RACE AND EDUCATION LEVEL**

	United States			California		
	2000	2004	Change 2000-2004	2000	2004	Change 2000-2004
<b>Overall Health Coverage</b>						
Male	81.9%	81.2%	-0.7%	77.1%	78.3%	1.2%
Female	83.4%	83.3%	-0.1%	78.2%	80.9%	2.7%
White	87.2%	86.8%	-0.4%	86.4%	87.4%	1.0%
African American	77.3%	78.7%	1.4%	77.9%	79.0%	1.1%
Latino	65.1%	65.6%	0.5%	64.8%	68.1%	3.3%
Asian	78.1%	79.4%	-1.3%	77.4%	81.7%	4.3%
No College	77.9%	76.2%	-1.7%	71.7%	72.1%	-0.4%
College Educated	91.0%	90.3%	-0.7%	88.3%	87.0%	-1.3%
<b>Total</b>	<b>82.7%</b>	<b>82.3%</b>	<b>-0.4%</b>	<b>77.7%</b>	<b>80.0%</b>	<b>2.3%</b>
<b>Employer-Based Coverage</b>						
Male	66.0%	61.9%	-4.1%	59.7%	56.1%	-3.6%
Female	65.3%	62.2%	-3.1%	56.9%	56.4%	-0.5%
White	72.2%	68.9%	-3.3%	68.9%	66.6%	-2.3%
African American	52.9%	50.0%	-2.9%	57.0%	49.1%	-7.9%
Latino	43.9%	41.2%	-2.7%	41.6%	42.2%	0.7%
Asian	62.8%	62.6%	-0.1%	61.8%	60.5%	-1.3%
No College	62.5%	58.2%	-4.3%	54.9%	51.2%	-3.7%
College Educated	82.6%	79.7%	-2.9%	77.8%	74.9%	2.9%
<b>Total</b>	<b>65.7%</b>	<b>62.1%</b>	<b>-3.4%</b>	<b>58.3%</b>	<b>56.3%</b>	<b>-2.0%</b>

SOURCE: MARCH CURRENT POPULATION SURVEY 2000-2004

**D. Adult Health Coverage**

In the last four years, health care coverage for adults dropped in the United States and remained stable in California. Health insurance among adults between the ages of 19-65 fell one percentage points nationwide. Low-income adults above the federal poverty line, many of whom are not eligible for public coverage, experienced the greatest drop-off. In California, coverage for adults between 200% and 400% of FPL declined by four percentage points, compared to a less than one percentage point decline for adults

above 400% of FPL (Table 7 on page 17).

Similar to health trends in the larger population, the loss of overall coverage for adults was fueled by the fall in job-based health insurance, both nationally and in California. Job-based coverage for adults in the United States fell from 68% to 64% and from 61% to 58% in California (Chart 7 and 8 on page 16).

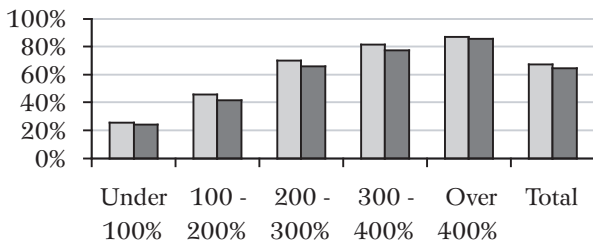
Employer-sponsored insurance for full-time, year-round workers dipped three percentage points in the United States and two percentage points in California,

**TABLE 5: INSURANCE COVERAGE FOR WORKING FAMILIES**

United States				California		
Percent of Federal Poverty Level	2000	2004	Change 2000-2004	2000	2004	Change 2000-2004
<b>Overall Health Coverage</b>						
Less than 100%	62.6%	63.5%	.9%	51.7%	61.9%	10.1%
100%-200%	71.6%	69.3%	-2.3%	59.0%	62.1%	3.1%
200%-300%	84.3%	83.4%	-1.0%	76.4%	78.1%	1.7%
300%-400%	91.2%	89.5%	-1.7%	85.6%	86.3%	0.7%
400% and Above	94.4%	94.6%	0.2%	92.9%	93.7%	0.7%
Total	86.5%	85.9%	-0.6%	76.9%	81.2%	4.3%
<b>Employer-Based Coverage</b>						
Less than 100%	30.2%	24.9%	-5.3%	22.2%	20.8%	-1.4%
100%-200%	55.2%	48.7%	-6.5%	47.5%	38.4%	-9.1%
200%-300%	76.3%	72.2%	-4.0%	71.3%	64.7%	-6.6%
300%-400%	85.8%	82.3%	-3.5%	80.3%	78.5%	-1.8%
400% and Above	89.9%	88.6%	-1.3%	87.8%	85.7%	-2.1%
Total	79.0%	76.1%	-2.9%	73.2%	69.8%	-3.4%
<b>Public Coverage</b>						
Less than 100%	27.1%	32.5%	5.3%	30.5%	36.8%	6.3%
100%-200%	12.2%	18.1%	5.9%	12.5%	21.4%	8.9%
200%-300%	4.0%	7.0%	3.0%	3.9%	8.7%	4.8%
300%-400%	1.9%	2.8%	0.9%	3.0%	4.3%	1.4%
400% and Above	0.9%	1.3%	0.4%	1.1%	1.2%	0.0%
Total	4.4%	6.3%	1.9%	5.5%	8.2%	2.7%

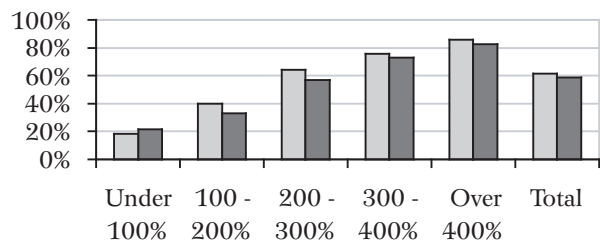
SOURCE: MARCH CURRENT POPULATION SURVEY 2000-2004

**CHART 7: JOB-BASED COVERAGE FOR ALL U.S. ADULTS**



SOURCE: MARCH CURRENT POPULATION SURVEY 2000-2004

**CHART 8: JOB-BASED COVERAGE FOR ALL ADULTS IN CALIFORNIA**



SOURCE: MARCH CURRENT POPULATION SURVEY 2000-2004

□ 2000    ■ 2004

**TABLE 6: EMPLOYER-BASED COVERAGE FOR YEAR ROUND, FULL TIME ROUND WORKERS**

Real Wages	United States			California		
	2000	2004	Change 2000-2004	2000	2004	Change 2000-2004
Below \$9/hr	38.2%	34.5%	-3.6%	30.6%	27.9%	-2.7%
\$9-\$11/hr	63.8%	57.7%	-6.1%	59.4%	45.9%	-13.5%
\$11-\$13/hr	70.7%	66.5%	-4.2%	66.2%	63.5%	-2.7%
\$13-\$15/hr	74.8%	72.2%	-2.5%	75.0%	68.5%	-6.5%
\$15-\$19/hr	79.4%	76.2%	-3.2%	76.7%	77.0%	0.3%
\$19-\$23/hr	83.8%	79.2%	-4.6%	81.5%	75.5%	-6.0%
\$23 and Above	85.6%	82.9%	-2.7%	84.9%	82.7%	-2.2%
<b>Total</b>	<b>69.5%</b>	<b>67.0%</b>	<b>-2.5%</b>	<b>65.9%</b>	<b>64.0%</b>	<b>-1.9%</b>

SOURCE: MARCH CURRENT POPULATION SURVEY 2000-2004

**TABLE 7: INSURANCE COVERAGE FOR ADULTS**

Percent of Federal Poverty Level	United States			California		
	2000	2004	Change 2000-2004	2000	2004	Change 2000-2004
<b>Overall Health Coverage</b>						
Less than 100%	58.3%	59.7%	1.3%	50.2%	56.7%	6.4%
100%-200%	67.1%	64.2%	-2.9%	60.9%	60.3%	-.6%
200%-300%	81.1%	78.7%	-2.3%	76.2%	71.2%	-5.0%
300%-400%	89.5%	86.8%	-2.6%	86.3%	83.0%	-3.3%
400% and Above	93.5%	93.7%	0.2%	92.4%	92.9%	0.5%
<b>Total</b>	<b>81.2%</b>	<b>80.1%</b>	<b>-1.2%</b>	<b>75.9%</b>	<b>76.4%</b>	<b>0.5%</b>
<b>Employer-Based Coverage</b>						
Less than 100%	25.3%	23.6%	-1.7%	18.7%	21.2%	2.4%
100%-200%	46.4%	40.8%	-5.6%	39.4%	32.9%	-6.6%
200%-300%	70.1%	65.4%	-4.7%	63.9%	56.9%	-7.0%
300%-400%	81.8%	77.4%	-4.4%	76.3%	72.8%	-3.5%
400% and Above	87.7%	86.3%	-1.4%	85.7%	83.1%	-2.6%
<b>Total</b>	<b>67.7%</b>	<b>64.0%</b>	<b>-3.7%</b>	<b>60.8%</b>	<b>58.1%</b>	<b>-2.7%</b>
<b>Public Coverage</b>						
Less than 100%	22.7%	24.1%	1.4%	23.3%	24.1%	0.8%
100%-200%	9.9%	11.5%	1.6%	14.5%	15.5%	1.0%
200%-300%	3.0%	4.3%	1.3%	3.0%	5.5%	2.5%
300%-400%	1.6%	1.9%	0.3%	2.8%	2.3%	-0.4%
400% and Above	0.7%	0.9%	0.2%	0.8%	1.0%	0.2%
<b>Total</b>	<b>6.1%</b>	<b>7.2%</b>	<b>1.1%</b>	<b>8.0%</b>	<b>8.6%</b>	<b>0.6%</b>

down to 67% and 64% respectively. Individual workers earning low-to-middle hourly wages were hit the hardest. Among low-income workers nationwide, employer-based coverage fell four percentage points to reach 35% for workers earning less than \$9 an hour, six percentage points to reach 58% for workers earning between \$9 and \$11 an hour, and four percentage points to reach 67% for workers earning \$11-\$13 an hour. In California, insurance decreased three percentage points for workers earning below \$9 an hour, a staggering fourteen percentage points for workers between \$9 and \$11/hour, and three percentage points for workers between \$11 and \$13 an hour. In 2004, job-based coverage for these workers was 28%, 46% and 64% respectively (Table 6 on page 17).

Despite the persistent erosion of employer-based coverage, the drop in the overall rate of health insurance was cushioned by a small growth in public coverage enrollment. In the last four years more adults enrolled in publicly funded health insurance programs, primarily through Medicaid. Public coverage for all adults increased one percentage point in both the United States and California to reach 7% and 9% respectively. Virtually the entire hike in enrollment was for low-income individuals, specifically for adults under 300% of FPL.

**E. Children’s Health Coverage**

Unlike the decline in adult coverage, insurance for children grew consistently over the last four years in California and nationwide. California, which began in 2000 with lower insurance rates than the nation, experienced a more noticeable jump in enrollment but still did not reach the national average. Children’s coverage rose over one percentage point in the United States as a whole and over five percentage points in California. Lower-income children accounted for a large portion of the overall boost. In California, coverage increased ten percentage points for children in families below 100% of FPL, four percentage points for children between 100% and 200% of FPL, and five percentage points for children between 200% and 300% of FPL. Nationally, coverage at these incomes levels increased, but at a slower rate: three percentage

points, two percentage points and two percentage points respectively (see Table 8).

Despite the overall expansion in coverage for children, job-based insurance trends resembled those of the rest of the population. Children in 2004 were less likely to receive health care through their parent’s employers than four years prior. Employer-based coverage among children fell by four percentage points nationwide and one percentage point in California. Low-income children experienced the most noticeable decline in job-based insurance. For children between 100% and 200% of FPL, coverage dropped thirteen percentage points in California and eight percentage points in the United States. Interestingly, this income/age group experienced the most dramatic decline of any group in California. Now only 32% of children in this income group statewide and 42% nationwide receive coverage through a parent’s employer, compared to the overall average for children of 54% and 60% respectively.

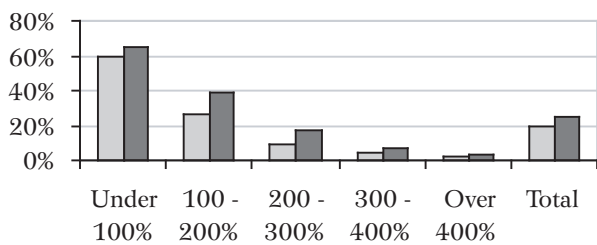
The growth in overall coverage for children is explained by a rise in enrollment in public health insurance plans. A significant jump in enrollment in Medicaid combined with the creation and expansion of the State Children’s Health Insurance Program (SCHIP) helped alleviate the loss of employer-sponsored coverage for many thousands of lower-income American children. Between 2000 and 2004, public enrollment for children rose from 19% to 25% nationally and from 24% to 29% in California. Low-income children, who represent the vast majority of those eligible for public coverage, experienced the biggest increases. In the United States, coverage climbed thirteen percentage points for children between 100% and 200% of FPL, eight percentage points for children between 200% and 300% of FPL and three percentage points for children between 300% and 400% of FPL. In California, increases at the same income levels were sixteen percentage points, nine percentage points and one percentage point respectively (Charts 9 and 10). Despite the noticeable decline in employer-sponsored health insurance among this population, the subsequent rise in public coverage prevented any overall loss of insurance.

**TABLE 8: INSURANCE COVERAGE FOR CHILDREN**

United States				California		
Percent of Federal Poverty Level	2000	2004	Change 2000-2004	2000	2004	Change 2000-2004
<b>Overall Health Coverage</b>						
Less than 100%	77.7%	80.8%	3.1%	73.2%	82.7%	9.5%
100%-200%	80.8%	82.6%	1.6%	74.5%	78.7%	4.2%
200%-300%	88.8%	90.7%	1.9%	84.4%	89.0%	4.6%
300%-400%	93.5%	93.8%	0.3%	90.6%	92.6%	2.0%
400% and Above	95.4%	96.0%	0.6%	92.9%	95.5%	2.7%
Total	87.8%	89.2%	1.4%	87.8%	5.2%	
<b>Employer-Based Coverage</b>						
Less than 100%	15.9%	12.3%	-3.6%	11.7%	11.4%	-0.2%
100%-200%	49.5%	41.6%	-7.9%	44.4%	31.8%	-12.6%
200%-300%	74.1%	70.0%	-4.2%	67.8%	65.8%	-2.1%
300%-400%	84.4%	82.0%	-2.4%	80.3%	79.2%	-1.0%
400% and Above	87.9%	87.2%	-0.7%	82.9%	83.5%	0.6%
Total	64.2%	60.1%	-4.1%	54.0%	-1.3%	
<b>Public Coverage</b>						
Less than 100%	59.5%	65.7%	6.2%	61.3%	68.7%	7.5%
100%-200%	26.7%	39.4%	12.6%	28.5%	45.1%	16.6%
200%-300%	8.7%	16.6%	7.9%	8.8%	18.1%	9.4%
300%-400%	4.4%	6.9%	2.5%	7.7%	8.5%	0.8%
400% and Above	2.3%	3.4%	1.1%	3.3%	3.2%	-0.1%
Total	18.9%	25.3%	6.3%	28.8%	5.3%	

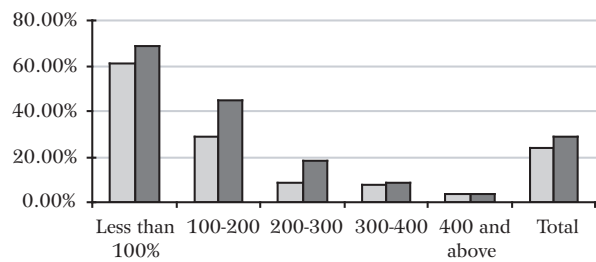
SOURCE: MARCH CURRENT POPULATION SURVEY 2000-2004

**CHART 9: PUBLIC COVERAGE FOR U.S. CHILDREN**



SOURCE: MARCH CURRENT POPULATION SURVEY 2000-2004

**CHART 10: PUBLIC COVERAGE FOR CA CHILDREN**



SOURCE: MARCH CURRENT POPULATION SURVEY 2000-2004



**F. Children’s Coverage by Ethnicity and Race**

Despite the decline in employer-based coverage, health insurance rose substantially among children, particularly for Latinos, African Americans and Asians in California. Between 2000 and 2004, insurance coverage jumped thirteen percentage points for African American children and nine percentage points for Asian and Latino children, while coverage for white children was unchanged. The increases in coverage greatly contributed to closing the health disparity gap between whites and all other racial and ethnic groups. By 2004, as reported in Table 9, 92% of white children had health insurance compared to 86% of African American children, 81% of Latino children and 92% of Asian children. Although African Americans and Latinos still have lower coverage rates both nationally and in California, the disproportionate rise in health coverage, primarily through enrollment in public coverage programs, has played a substantial role in closing the coverage gap between white children and other racial and ethnic groups.

**G. Health Care Premium Costs**

Over the last twenty years, health care costs have fluctuated significantly. Economic cycles, changes in the financial structure of care and inefficiencies in the

health care industry have all contributed to the pace of growth in the cost of health care. Premiums for a family reached a peak growth rate of 18% annually during the late 1980’s before falling to 14% in 1990. The introduction of managed care in the late 1980’s and early 1990’s reformed the cost structure, leading to declining growth rates throughout the early and mid 1990’s. The downward trend continued through 1996 when health care premiums rose less than one percentage point. This was well below the overall rates of inflation and growth in workers’ earnings, which varied between three and four percent. However, since 1996, health care costs have resumed their rapid growth.

In the last four years, health care premiums for employer-based coverage have skyrocketed. Both family and individual coverage underwent sharp increases, creating additional costs to employers and to many workers. In the United States, the annual cost of job-based family coverage grew from \$6,567 in 2000 to \$9,831 in 2004, a 50% escalation that translates to an annual average growth of 11%. Similarly in California, health care premiums for family coverage climbed 43% between 2000 and 2003, from \$5,890 to \$8,422 – an average annual growth rate of 13%. The cost of individual coverage grew at an annual rate of 11% nation-

**TABLE 9: INSURANCE COVERAGE FOR CHILDREN BY RACE AND ETHNICITY**

	United States			California		
	2000	2004	Change 2000-2004	2000	2004	Change 2000-2004
<b>Overall Health Coverage</b>						
Male	86.4%	88.0%	1.6%	83.0%	86.6%	3.6%
Female	86.1%	87.9%	1.8%	80.1%	87.3%	7.2%
White	90.8%	91.6%	0.8%	90.9%	91.6%	-0.7%
African American	82.1%	85.0%	2.9%	73.5%	86.1%	12.6%
Latino	72.7%	78.5%	5.8%	72.6%	81.4%	8.8%
Asian	83.2%	86.3%	3.1%	82.4%	91.7%	9.3%
Total	86.3%	88.0%	1.7%	81.7%	87.0%	5.3%

SOURCE: MARCH CURRENT POPULATION SURVEY 2000-2004

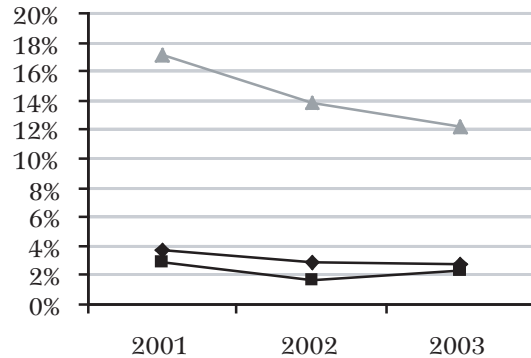
wide and 10% in California. By 2004, the average annual cost of individual coverage was \$3,862 in the United States as a whole (Table 10).

This dramatic acceleration in premiums also signaled a noticeable shift in employer behavior. By 2004, employers were shifting a greater percentage of additional health costs to employees, increasing the financial burden for working families. In 2000, workers nationwide and in California paid 25% of the total cost of family coverage, with employers responsible for the remaining 75%. By 2004, worker contributions were up to 32% and 30% in California. The average share of costs for individual coverage also rose slightly. In 2000, workers paid 10% nationwide and 12% in California of the cost of individual health coverage. By 2004, worker contributions had grown to 15% in both California and nationwide.

The average national worker contribution for family coverage rose 89%, from \$1,670 in 2000 to \$3,156 in 2004. The average worker contribution to individual coverage rose 122% from \$259 in 2000 to \$576

in 2004. The average worker contribution in California for family coverage rose 68% from \$1,477 in 2000 to \$2,552 in 2003 (latest year available); the average contribution for individual coverage rose 68% from \$271 to \$454.

CHART 11: ANNUAL GROWTH RATES



SOURCE: KFF/HRET, EMPLOYER HEALTH BENEFIT SURVEY; BUREAU OF LABOR STATISTICS, CONSUMER PRICE INDEX, U.S. CITY AVERAGE OF ANNUAL INFLATION; BUREAU OF LABOR STATISTICS, AVERAGE HOURLY EARNINGS, SEASONALLY ADJUSTED DATA FROM THE NATIONAL COMPENSATION SURVEY

◆ Earnings ■ Inflation ▲ US: Family Health Care Premiums

TABLE 10: AVERAGE ANNUAL PREMIUM AND AVERAGE WORKER CONTRIBUTION

YEAR	Average Annual Family Premium	Average Worker Contribution	Average Individual Premium	Average Worker Contribution
<b>US</b>				
2000	\$6,567	\$1,670	\$2,557	\$259
2001	\$6,603	\$2,022	\$2,710	\$288
2002	\$7,695	\$2,308	\$3,213	\$439
2003	\$8,760	\$2,621	\$3,418	\$364
2004	\$9,831	\$3,156	\$3,862	\$576
<b>CA</b>				
2000	\$5,890	\$1,477	\$2,267	\$271
2001	\$6,273	\$1,536	\$2,348	\$306
2002	\$7,361	\$1,923	\$2,796	\$376
2003	\$8,422	\$2,552	\$3,048	\$454

SOURCE: KFF/HRET, EMPLOYER HEALTH BENEFIT SURVEY 2000-2004

To understand the financial impact of rising health care costs on employees, we compared the growth in health care costs to other economic indicators. When measured against earnings and inflation throughout the same time period, health care costs grew at a substantially faster rate. Between 2000 and 2004, annual inflation fluctuated between a high of 3.3% and a low of 1.5%. The growth rate of average hourly earnings varied between 3.8% and 2.1% annually, while

health care costs grew at an annual rate of 10.6% over the same time period (Chart 11). The noticeable difference between the acceleration of health costs and other economic variables demonstrates that the growth in income has not kept pace with the rise in health expenses. Combined with the increased share of costs for employees, this relationship indicates that workers are now allocating a greater percentage of annual income to health care expenses.



**THE EFFECT OF INCREASING PREMIUMS ON COVERAGE**

**A. Ways that Rising Premiums Costs Affect Health Insurance Coverage**

Previous research finds that job-based coverage responds substantially and in a number of ways to changes in health care premium costs. Most importantly, employers respond to rising premium costs by a combination of shifting costs to workers, restricting eligibility, and trimming benefits.

Studying the period of 1988-97, Farber and Levy (1998) concluded that decreases in employer coverage are manifested by (1) declines in take-up among long term, full-time employees, and (2) declines in eligibility for part-time and new employees. Evidence from the more recent period supports the idea that employers have raised the eligibility hurdles for health coverage. Following a bitter four-and-a-half month strike and lock-out in Southern California supermarkets, the three major grocery companies lengthened the waiting periods for new workers to 12 months for individual coverage and 30 months for family coverage. Dube and Lantsberg (2004) estimated that given historical tenure distribution at these companies, coverage for the 70,000 workers would decline from close to 100% in 2003 to 74% under the new contract on account of longer waiting periods alone.

Besides restricting eligibility, employers also raise worker contributions, which in turn reduce take-up. As the previous section reported, over the past five years employers have sharply reduced the contributions workers must make to enroll in single and family health benefits plans. To date,

studies have found that an increase in employee contributions towards premiums modestly reduces the take-up rate. However, Blumberg, Nichols and Banthin (2002) found lower-income workers are more sensitive to increases in contribution than higher-income workers, and family members are more sensitive than singles. Studies of take-up elasticity of public coverage have found much greater price sensitivity.

Greater responsiveness among poorer workers and family members is not surprising. Rising costs disproportionately affect families with lower incomes. Hudman and Mark (2002) found that 23% of families with incomes below the poverty line spend more than the recommended five percent of their incomes on out-of-pocket health care expenses, compared to three percent of families with incomes above 400% of FPL. A 2004 Families USA report noted that 1.7 million Californians under the age of 65 were expected to spend at least one-fourth of their total earnings on health care.

Finally, employers may respond to cost pressures by changing benefit quality, including the range of covered services as well as deductibles and co-payments. These also may affect take-up rates. As deductibles and co-payments increase, lower-wage workers may choose not to pay high premium costs for a plan that does not meet their ongoing health care needs.

In this study, we will quantify how premium increases affects overall coverage, which allows for all these various channels to be in play.

**B. Controlling for Other Factors Affecting Health Coverage**

Besides premium costs, there are other factors which influence health coverage. In this section we identify the key candidates, and discuss how our methodology controls for some of these potentially confounding factors as we quantify the relationship between premium cost and coverage. Most obviously, access to jobs is an important driver. To account for this feature, in our estimates below, we focus only on year-round workers and working family members. Two related concerns are part-time jobs and self-employment, as health coverage is less likely to be available for such positions. For this reason, in our regressions we control for part-time work and self-employment of the relevant family members.

Similarly, we control for jobs that have short tenure (less than one year); given the existence of waiting periods, an increase in jobs with short tenure can be a confounding factor. Family income, too, influences the likelihood of coverage: other things equal, a lower family income makes the purchase of health insurance more difficult. Consequently, we control for any such changes in income. Finally, we also control for industry and firm size composition of jobs, as changes in such composition (i.e., from manufacturing to services, or from larger to smaller firms) may also exert a downward pressure on the availability of job-based coverage.

**C. Regression Methodology**

To estimate empirically the impact of rising premium costs on health coverage and to project future trends, we estimated a regression model to measure the impact of higher premiums on coverage rates among children and adults. The analysis focuses specifically on how an increase in premiums affects employer-based coverage, the uninsurance rate, private coverage and public coverage for the following populations: working adults, dependent adults with a working spouse, and children with working parents.

The regression model is primarily based on household

data from the March supplement to the Current Population Survey (CPS) between the years of 2000 and 2004. This data is augmented by the information on premiums for single and family job-based plans from the Kaiser Family Foundation Employer Health Benefits Survey, sorted by year and region. The regression model jointly estimates how the odds of having job-based, private, or public coverage as well as uninsurance respond to an increase in premium cost. These responses are estimated for different family types and different state-level public insurance eligibilities. The regression model controls for demographic factors such as age, gender, race, education levels, family characteristics, industry and job characteristics (of workers or working parents or spouses), as well as state-specific factors that may influence the level of coverage (Table 11). Details on data and the regression methodology can be found in Appendix A. The Appendix also contains details on the regression results, statistical significance of coefficients, and comparisons to the existing literature.

**TABLE 11: REGRESSION MODEL**

**Outcomes:**

- Employer-based coverage
- Uninsurance
- Private Coverage
- Public Coverage

**Test:**

Impact of a 10% increase in premium cost by five family income categories and public insurance eligibility levels

**Controls:**

- Age, Gender, Race, Education, Industry, Firm Size, Full/Part Time Job, Job Tenure, Family Size, Number of Children in Family, State Dummy

**Estimated Separately For:**

- Working Adults
- Dependent Adults with a Working Spouse
- Children with Working Parents

**D. Regression Results: Effects of Premium Increases**

**ADULTS**

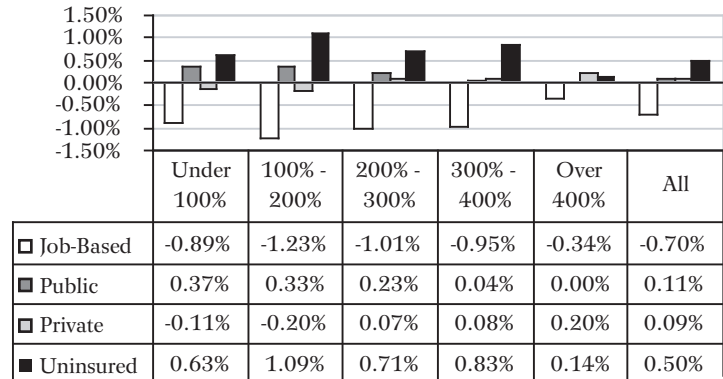
Higher health care premiums generate negative outcomes for both working adults and their dependents, resulting in lower employer-based coverage and higher uninsurance rates. Lower-income adults are the most affected by the rise in health costs. Given a 10% increase in premiums, both working adults and dependent adults experience a steep fall in employer-based coverage, resulting in a steep increase in uninsurance.

Among working adults, higher health care premiums reduces employer-based coverage while triggering a rise in uninsurance, private insurance and public coverage rates. With every ten percent growth in premiums, all else being equal, employer-sponsored coverage for workers nationally decreases 0.7% while the uninsurance rate, private coverage and public coverage increase by 0.50%, 0.09% and 0.11% respectively (Chart 12).

Job-based coverage for workers below 400% of FPL falls sharply with the rise in premium costs. As shown in Chart 12, for workers under 400% of FPL, employer-based coverage drops by between 0.89% and 1.23% in response to a 10% increase in premium cost. In contrast, job-based coverage declines by 0.34% for workers in families above 400% of FPL. Most of the reduction in job-based coverage translates into a rise in uninsurance. This is especially true for those in families between 300% and 400% of FPL, who are not typically eligible for a public plan. For this group of workers, given a 10% rise in premium costs, uninsurance goes up by 0.83% nearly matching the 0.95% decline in job-based coverage. Increased enrollment in public cov-

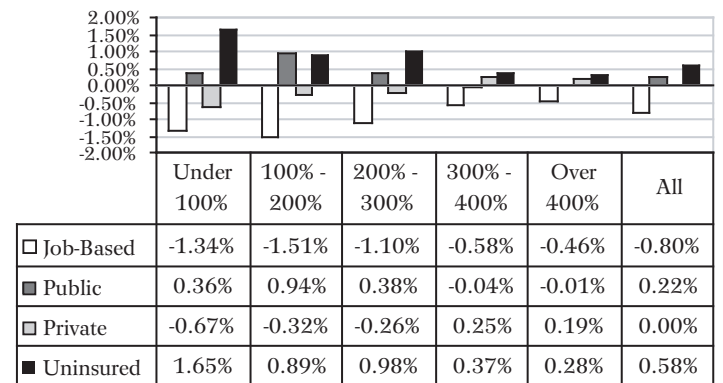
erage offsets some of loss in employment-based coverage for lower-income workers; those in families between 100% and 200% of FPL see a 0.33% rise in public coverage concomitant with a 1.23% decline in job-based coverage. The response of job-based coverage and uninsurance to health premiums is statistically significant at the 5% level for all income categories, and so is the public coverage response for workers in families below 300% of FPL.

**CHART 12: COVERAGE RESPONSE TO A 10% INCREASE IN PREMIUMS: U.S. WORKING ADULTS**



SOURCE: MARCH CURRENT POPULATION SURVEY, KFF/HRET EMPLOYER HEALTH BENEFITS SURVEY

**CHART 13: COVERAGE RESPONSE TO A 10% INCREASE IN PREMIUMS: U.S. ADULT DEPENDENTS**



SOURCE: MARCH CURRENT POPULATION SURVEY, KFF/HRET EMPLOYER HEALTH BENEFITS SURVEY

Dependent adults with a working spouse also experience a drop-off in employer-based coverage in response to price increases, but are somewhat more likely to enroll in public insurance. For every 10% rise in health care premiums, overall employer-based coverage for this group drops by 0.80%, and uninsurance and public coverage rise by 0.58% and 0.22%, respectively. Private coverage increases slightly, though this rise is not statistically significant (Chart 13).

The most noticeable responses in employment-based coverage yet again occur among lower-income families, and are somewhat larger than coverage for working adults. For dependent adults in families under 300% of FPL, 10% higher premiums cause job-based coverage to decrease by between 1.10% and 1.34%. In contrast, employment-based coverage drops by 0.58% and 0.46% for dependants in families between 300% and 400% of FPL and above 400% of FPL, respectively. (All the employment-based coverage responses are statistically significant.)

Uninsurance also rises more dramatically for lower-income, dependent adults. For adults below 100% of FPL, uninsurance rises (1.65%) by more than the decline in job-based coverage (1.34%). Interestingly, adults between 100% and 200% of FPL see a rise in

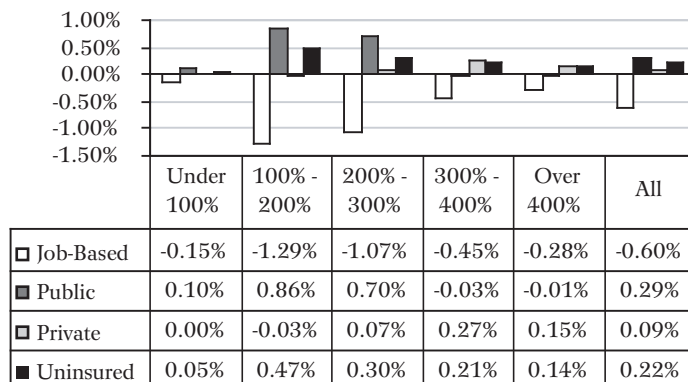
uninsurance of (0.89%) but also experience a large jump in enrollment in public coverage (0.94%). As before, public coverage response becomes statistically indistinguishable from zero for families at or above 300% of FPL, as these individual are typically ineligible for such coverage. Overall, private coverage seems to fall somewhat more for dependent adults than for working adults in lower-income families, though the differences are within the statistical margin of error.

**CHILDREN**

As mentioned previously, the implementation of state-level SCHIP programs in this period led to increased public coverage and reduced uninsurance for children. This poses a potential problem for using over-time variation in premium prices to estimate changes in various types of coverage and uninsurance, as over this same period utilization of public coverage rises simply from implementation of a new program (SCHIP). Furthermore, when SCHIP was implemented, enrollment grew not only in that program but also in Medicaid. Medicaid, which insures children below 100% of FPL, experienced a 17% percent jump in the number of beneficiaries nationwide between 2000 and 2003. Since such an initial increase in public coverage (and attendant drops in uninsurance) is typically a feature of the first few years of implementation, it is important to distinguish that dynamic from the response to the ongoing premium price increases. Our model accounts for such an initial increase in public program participation and a fall in uninsurance through a difference-in-difference strategy, using coverage changes among non-working family children as a control; these children are affected by the SCHIP implementation but not by increases in premium prices. Consequently, the premium responses reported below are net of any changes due to the initial spurt in public coverage; details of this methodology are available in Appendix A.

Children with working parents see a fall

**CHART 14: COVERAGE RESPONSE TO A 10% INCREASE IN PREMIUMS: U.S. CHILDREN**



SOURCE: MARCH CURRENT POPULATION SURVEY, KFF/HRET EMPLOYER HEALTH BENEFITS SURVEY

in employment-based coverage and a rise in public coverage and uninsurance in response to a growth in premiums. As Chart 14 shows, every 10% jump in health costs for this population results in a decline in employer-based coverage of 0.60%. At the same time, private, public coverage and uninsurance increase by 0.09%, 0.29%, and 0.22% respectively. There seems to be considerable heterogeneity in response to premiums by family income. For children below 100% of FPL, there is no statistically significant change in any type of coverage. In contrast, those between 100% and 300% of FPL experience a sharp drop in employer-based coverage (between 1.07% and 1.29%). In families with income above 300% of FPL, where few children are eligible for public coverage, a larger part (half) of the drop in employment-based coverage is absorbed by increased uninsurance (Chart 14).

**E. National Impact of Premium Cost Increases**

Using the response rates reported above we can calculate the impact of a 10% rise in premium costs on the numbers of U.S. individuals with access to insurance. At current population levels, a 10% increase in health insurance premiums means 1.3 million fewer full-time working family members are insured at the job. This translates into 817,000 more uninsured individuals and 380,000 more enrollees in public plans. A 10% increase in family premium implies 442,000 fewer children insured by employment-based plans, 163,000 more uninsured children and an increase of

217,000 in enrollment for SCHIP and Medicaid (Table 12).

**F. Future Projections: The Effect of Increasing Premiums on Coverage Rates**

To estimate the impact of higher premiums on families, we simulated price increases based on our national-level regression estimates in 2004. The simulation model predicts the effect of a premium increases on employer-based coverage, public coverage, private coverage and the uninsurance rate of the country’s non-elderly population. Our “baseline” scenario (reported below) assumes an annual premium price growth of 10%, which is in line with recent experience (premiums have increased at a rate between 10% and 14% over the past four years).

To be clear, our future projections are based only on the effect of ongoing premium price increases. Surely, there are other factors that may influence overall coverage rates. For instance, a tighter labor market and more people with jobs will tend to increase the rate of employment-based coverage. On the other hand, if new jobs are “worse” than old jobs in terms of odds of providing health coverage, this will put a downward pressure on the number of Californians receiving insurance at their workplace. Similarly, policy changes – ranging from altered eligibility levels to more intense outreach efforts to recruit currently eligible individuals – influence public coverage levels. We do not attempt to predict such macroeconomic or policy factors in the analysis that follows. Consequently, the projections here demonstrate how

we can expect health coverage to change solely due to rising premium costs, all else equal.

**TABLE 12: NATIONAL RESPONSE TO A 10% INCREASE IN PREMIUM COSTS FOR WORKING FAMILIES**

	<b>ESI</b>	<b>Public</b>	<b>Private</b>	<b>Uninsured</b>
Adults	-910,000	164,000	92,000	654,000
Children	-442,000	217,000	63,000	163,000
All	-1,352,000	380,000	155,000	817,000

SOURCE: MARCH CURRENT POPULATION SURVEY, KFF/HRET EMPLOYER HEALTH BENEFITS SURVEY

**HEALTH CARE COVERAGE PROJECTIONS FOR THE U.S.**

**A. Predictions for All Non-Elderly Individuals (Adults and Children)**

Assuming annual increases of 10% in health insurance premiums, employer-sponsored insurance will decline for all non-elderly Americans from 63% to 59% between 2004 and 2010 (Chart 15). Although job-based coverage will drop at all income levels, Americans in the low-to-middle income groups (100% to 400% of FPL) will experience the most significant declines.

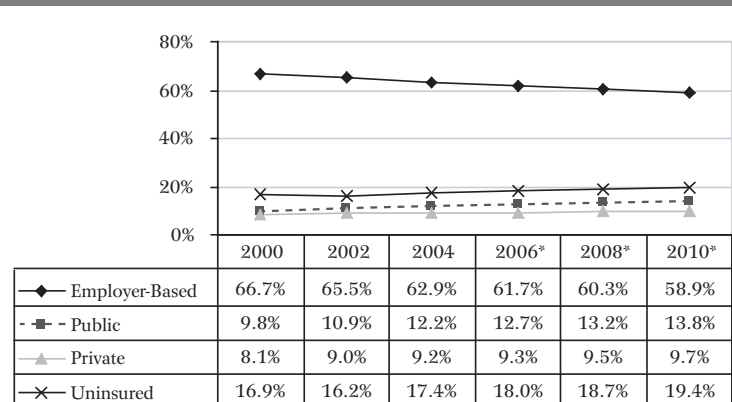
For individuals with incomes above 400% FPL, who represent the top 42% of the population in terms of income, job-based coverage is predicted to decline by three percentage points, from 87% to 84% (Chart 17 on page 29 and Table 13 on page 30). For those with incomes below 100% of FPL, the vast majority of whom already lack job-based coverage, employer-sponsored insurance will decline by less than one percentage point, from 20.3% to 19.6%. This group constitutes the bottom 22% of the population by income (Table 13 on page 30).

However, coverage will decline by seven percentage points for those at 100-200% FPL, from 41% to 34%; seven percentage points for those between 200%-300% FPL, from 67% to 60% and almost six percentage points for those just above median income at 300-400% FPL,

from 79% to 73%. Nationally, 76% of those who are newly uninsured from 2004 to 2010 will be in the low- and middle-income groups represented by the 100% to 400% of FPL categories, although this group accounted for only 53% of the uninsured in 2004 (Table 13 on page 30 and Chart 19 on page 31). This entire group constitutes 36% of the population by income.

For those with incomes under the approximate median of 300% of FPL, the rise in public insurance will offset part of the decline in job-based health coverage. By 2010, the percentage of those under 300% of FPL with public coverage will rise three percentage points from 22% to 25%, with the greatest increase—a five percentage point rise from 21% to 26%—for those in the 100-200% FPL category, due to the dramatic seven point decline in job-based coverage

**CHART 15: PAST AND PREDICTED COVERAGE TRENDS FOR ALL NON-ELDERLY IN THE U.S.**



SOURCE: ANALYSIS USING MARCH CPS AND KFF/HRET EMPLOYER HEALTH BENEFITS SURVEY

combined with wide eligibility for public programs (Chart 16 and 18).

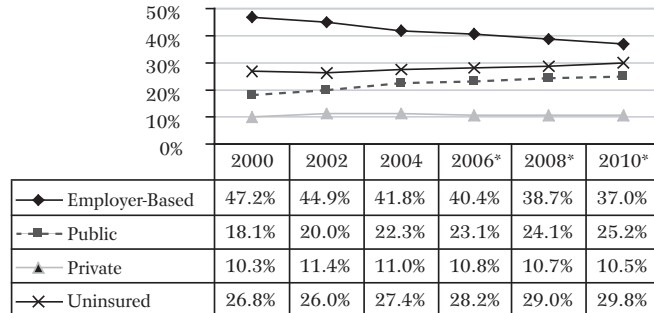
However, middle-income individuals (those who straddle the median, between 200% and 400% of FPL) will comprise of half (49%) of the newly uninsured (Chart 19 on page 31). For those with incomes between 200% and 300% of FPL, uninsurance will increase by three percentage points, from 18% to 21%; while for those with incomes just above the median, between 300% and 400% of FPL, uninsurance will increase by four percentage points, from 11% to 15% (Table 13). These groups will see some of the greatest drops in coverage, but are also limited in terms of public program eligibility, so will see the greatest rise in uninsurance. A small percentage of these individuals will purchase private coverage, with a rise of 0.1% for the 200%-300% FPL group, and a slightly larger increase of 1.3% for the 300%-400% FPL group.

Finally, for individuals above 400% of FPL, the 2.5% decline in job-based coverage will be partially offset by a 1.6% increase in private coverage, with the result that uninsurance will rise by only 1.1% for this group (Table 13 on page 30).

Assuming annual increases of 10% in health insurance premiums, employer-sponsored insurance will decline for all non-elderly Americans from 63% to 59% between 2004 and 2010. Although job-based coverage will drop at all income levels, Americans in the lower-to-middle income groups (100% to 400% of FPL) will experience the most significant declines.

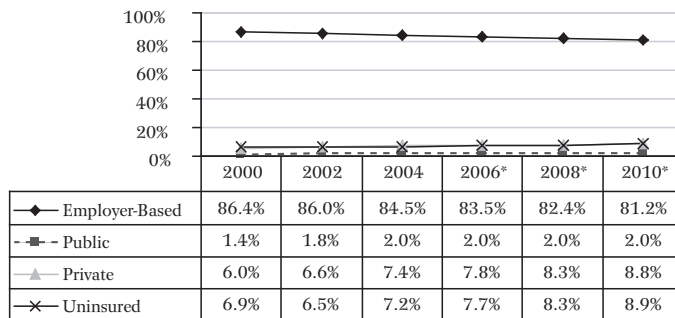
Based on our simulation results we can project the number of non-elderly

**CHART 16: PAST AND PREDICTED COVERAGE TRENDS FOR ALL U.S. NON-ELDERLY BELOW 300% OF FPL**



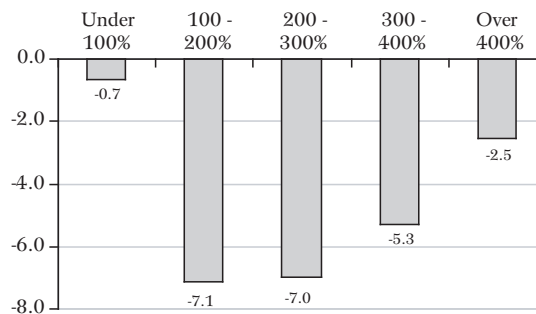
SOURCE: ANALYSIS USING MARCH CPS AND KFF/HRET EMPLOYER HEALTH BENEFITS SURVEY

**CHART 17: PAST AND PREDICTED COVERAGE TRENDS FOR ALL U.S. NON-ELDERLY ABOVE 300% OF FPL**



SOURCE: ANALYSIS USING MARCH CPS AND KFF/HRET EMPLOYER HEALTH BENEFITS SURVEY

**CHART 18: PREDICTED REDUCTION IN JOB-BASED COVERAGE: ALL U.S. NON-ELDERLY**



SOURCE: ANALYSIS USING MARCH CPS AND KFF/HRET EMPLOYER HEALTH BENEFITS SURVEY

**TABLE 13: PAST AND PREDICTED HEALTH COVERAGE FOR ALL AMERICANS 2004-2010**

FPL	2004	2005*	2010*
<b>Employer-Based Coverage</b>			
Under 100% of FPL	20.3%	20.1%	19.6%
100%-200% of FPL	41.1%	39.9%	33.9%
200%-300% of FPL	66.8%	65.6%	59.8%
300%-400% of FPL	78.7%	77.8%	73.4%
Over 400% of FPL	86.5%	86.1%	84.0%
Total	62.9%	62.3%	58.9%
<b>Public Coverage</b>			
Under 100% of FPL	36.5%	36.6%	37.1%
100%-200% of FPL	20.8%	21.6%	25.5%
200%-300% of FPL	8.1%	8.7%	11.7%
300%-400% of FPL	3.3%	3.4%	3.6%
Over 400% of FPL	1.5%	1.5%	1.4%
Total	12.2%	12.5%	13.8%
<b>Uninsured</b>			
Under 100% of FPL	34.1%	34.1%	34.5%
100%-200% of FPL	29.7%	30.2%	33.1%
200%-300% of FPL	17.6%	18.1%	20.8%
300%-400% of FPL	11.2%	11.8%	14.8%
Over 400% of FPL	5.7%	5.9%	6.8%
Total	17.4%	17.6%	19.5%
<b>Private Coverage</b>			
Under 100% of FPL	11.1%	11.1%	10.8%
100%-200% of FPL	11.7%	11.5%	10.6%
200%-300% of FPL	10.0%	10.0%	10.1%
300%-400% of FPL	8.1%	8.3%	9.4%
Over 400% of FPL	7.1%	7.4%	8.7%
Total	9.2%	9.3%	9.7%
SOURCE: ANALYSIS USING MARCH CPS AND KFF/HRET EMPLOYER HEALTH BENEFITS SURVEY			



Americans who will be covered by different health insurance programs in 2010. Between 2004 and 2010 we expect the non-elderly population in the United States to grow from 258 million to 270.5 million. Taking into account population growth, and given a 10% increase in health care premiums, three million fewer individuals will be insured through an employer-based plan, nearly six million more will be enrolled in a public program, two and a half million more will be insured through a private plan and eight million more will be uninsured. Thus, 52.6 million Americans will be uninsured by the end of the decade (Charts 20 and 21).

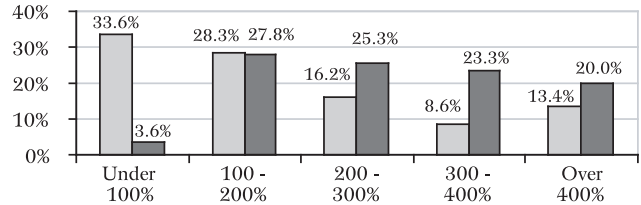
**B. Predictions for U.S. Adults (19-65)**

For U.S. adults, employer-based coverage is predicted to decline overall by four percentage points, from 64% to 60% (Chart 22 on page 32 and Table 14 on page 34). As for the entire non-elderly population, the drop will be concentrated in the low-to-middle income groups between 100% and 400% of FPL, with a decrease of nearly six percentage points (41% to 35%) for those at 100% to 200% of FPL; six percentage points (65% to 59%) for those at 200% to 300% of FPL; and almost six percentage points again (77% to 71.5%) for adults between 300% and 400% of FPL (Chart 24 on page 32).

Low- and-middle income adults will also experience the greatest increase in uninsurance. Nearly 80% of the newly uninsured between 2004 and 2010 will be adults whose incomes fall between 100% and 400% of FPL (Chart 23 on page 32 and 25 on page 33).

By contrast, 42% of U.S. adults with incomes above 400% of FPL will experience a two-percentage point decline, from 86% to 84%, and the lowest income group (100% of FPL and below), who represent 22% of U.S. adults, will see only a one-percentage point decline in job-based coverage, from 24% to 23% (Table 14 on page 34).

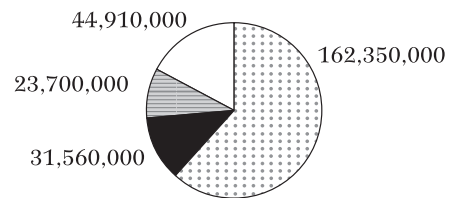
**CHART 19: CURRENT AND NEWLY UNINSURED NON-ELDERLY U.S. POPULATION**



SOURCE: ANALYSIS USING MARCH CPS AND KFF/HRET EMPLOYER HEALTH BENEFITS SURVEY

Legend: Current Uninsured (light gray), Newly Uninsured (dark gray)

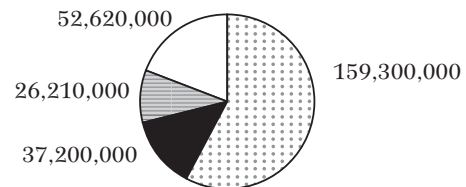
**CHART 20: HEALTH COVERAGE FOR ALL NON-ELDERLY IN THE U.S., 2004**



SOURCE: ANALYSIS USING MARCH CPS AND KFF/HRET EMPLOYER HEALTH BENEFITS SURVEY

Legend: Employer-Based (dotted), Public (solid black), Private (horizontal lines), Uninsured (white)

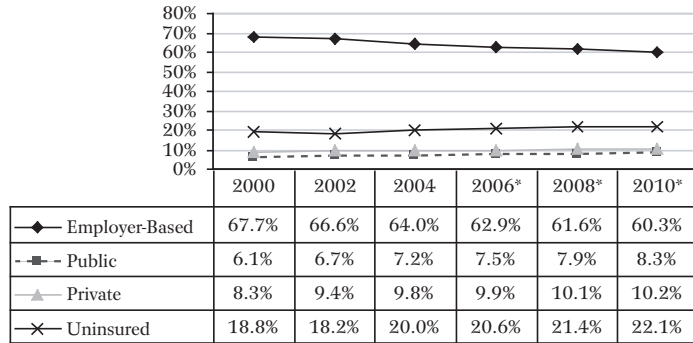
**CHART 21: PREDICTED HEALTH COVERAGE FOR ALL NON-ELDERLY IN THE U.S., 2010**



SOURCE: ANALYSIS USING MARCH CPS AND KFF/HRET EMPLOYER HEALTH BENEFITS SURVEY

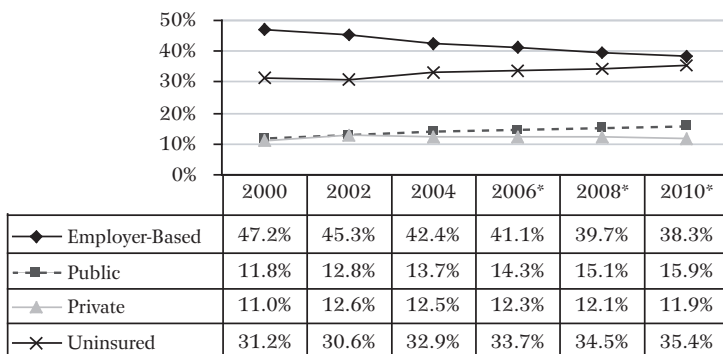
Legend: Employer-Based (dotted), Public (solid black), Private (horizontal lines), Uninsured (white)

**CHART 22: PAST AND PREDICTED COVERAGE TRENDS FOR ALL U.S. ADULTS**



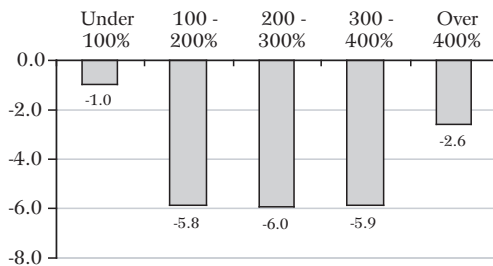
SOURCE: ANALYSIS USING MARCH CPS AND KFF/HRET EMPLOYER HEALTH BENEFITS SURVEY

**CHART 23: PAST AND PREDICTED COVERAGE TRENDS FOR ALL U.S. ADULTS BELOW 300% OF FPL**



SOURCE: ANALYSIS USING MARCH CPS AND KFF/HRET EMPLOYER HEALTH BENEFITS SURVEY

**CHART 24: PREDICTED REDUCTION IN JOB-BASED COVERAGE: U.S. ADULTS**



SOURCE: ANALYSIS USING MARCH CPS AND KFF/HRET EMPLOYER HEALTH BENEFITS SURVEY

Using our simulation results and projected population growth we can estimate how many adults will be insured through different health programs by 2010. Between 2004 and 2010, the national adult population is expected to grow from 186 million to 195 million. If we account for both population growth and our simulation results, by the end of the decade one and a half million fewer adults will be receiving health insurance through their employer, nearly three million more will be on a public program and six million more will be uninsured (Charts 26 and 27). By 2010, more than 43 million American adults will be living without health insurance.

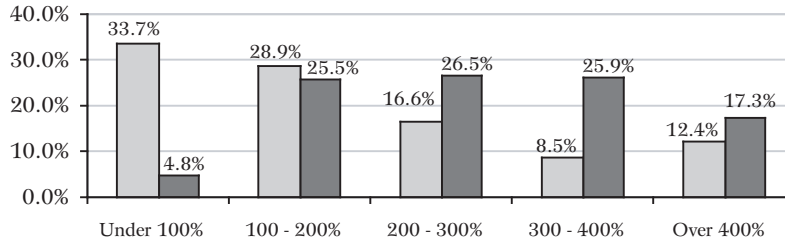
**C. Predictions for U.S. Children**

Job-based health coverage is predicted to decline overall by five percentage points for American children between 2004 and 2010, from 60% to 55% (Chart 28).

The sharpest drops in job-based coverage for children will affect those in the low-to-moderate income groups, or 100%-300% of FPL, who will see declines ranging from nine to ten percentage points (70% to 61% for the 200%-300% of FPL group, and 42% to 32% for those just above the federal line at 100% to 200% of FPL). These groups will represent well over half of the newly insured children (58%) (Table 14 on page 34, Chart 30 and 31 on page 35).

By contrast, children over 400% of FPL will see just a two percentage point drop from 87% to 85%, and children with incomes ranging from 300% to 400% of FPL will see a slightly larger drop of four percentage points from 82% to 78%. Children living below the federal poverty level, 65% of whom already receive pub-

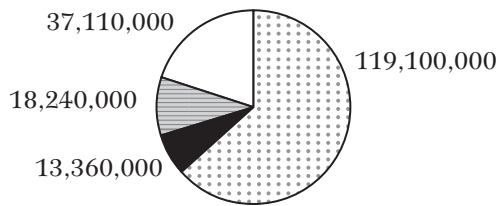
**CHART 25: CURRENT AND NEWLY UNINSURED U.S. ADULTS**



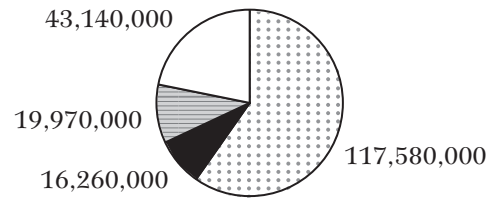
SOURCE: ANALYSIS USING MARCH CPS AND KFF/HRET EMPLOYER HEALTH BENEFITS SURVEY

Legend: Current Uninsured (light gray), Newly Uninsured (dark gray)

**CHART 26: HEALTH COVERAGE FOR ALL U.S. ADULTS, 2004**



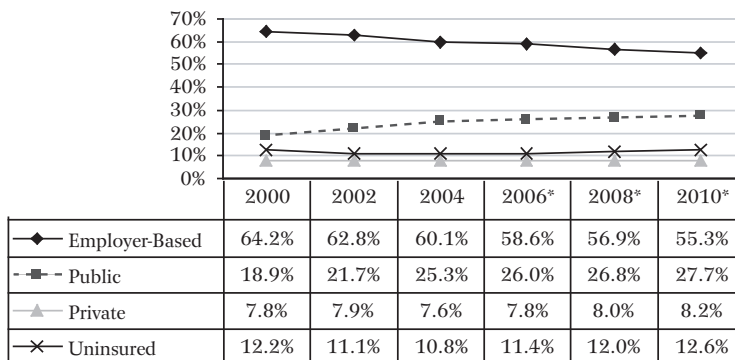
**CHART 27: PREDICTED HEALTH COVERAGE FOR ALL U.S. ADULTS, 2010**



SOURCE: ANALYSIS USING MARCH CPS AND KFF/HRET EMPLOYER HEALTH BENEFITS SURVEY

Legend: Employer-Based (dotted), Public (solid black), Private (horizontal lines), Uninsured (white)

**CHART 28: PAST AND PREDICTED COVERAGE TRENDS FOR ALL U.S. CHILDREN**



SOURCE: ANALYSIS USING MARCH CPS AND KFF/HRET EMPLOYER HEALTH BENEFITS SURVEY

lic coverage, and only 12% of whom had employer-sponsored insurance in 2004, will see no decline in job-based care by 2010.

For children in contrast to adults, the decline in job-based coverage will result in a sizable increase in public coverage for low-to-moderate income children that will mitigate the growth in uninsurance. In fact, for children under the approximate median income level of 300% of FPL, public coverage will supercede job-based coverage as the primary means of health care delivery by 2010. Whereas in 2000 job-based coverage accounted for 47% versus 31% of children receiving public coverage, and in 2004 job-based and public coverage each covered about 41% of children in this group, by 2010 job-based coverage will cover only 34% of U.S. children under median income, while 45% will have public coverage (Chart 29 and 31 on page 35).

Children above median income in the 300% to 400% of FPL group, who will be losing coverage at a rate of four percentage points but who are not eligible for public programs, will see an increase in private coverage, from 8% to 10% (Table 15 on page 36).

To estimate the number of children in the next six years who will become uninsured or enroll in a public program, we used our results from the simulation model with predicted population growth. Between 2004 and 2010, the number of children in the United States is expected to increase by three and a half million from 72.0 to 75.5 million. By 2010, assuming health care costs continue to increase at double-digit levels, and accounting for

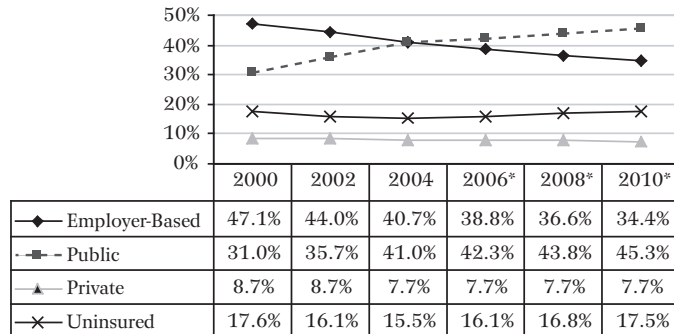
**TABLE 14: PAST AND PREDICTED HEALTH COVERAGE FOR ALL U.S. ADULTS, 2004-2010**

FPL	2004	2005*	2010*
<b>Employer-Based Coverage</b>			
Under 100% of FPL	23.63%	23.46%	22.65%
100%-200% of FPL	40.77%	39.80%	34.93%
200%-300% of FPL	65.35%	64.36%	59.40%
300%-400% of FPL	77.38%	76.40%	71.49%
Over 400% of FPL	86.32%	85.89%	83.74%
Total	64.04%	63.42%	60.28%
<b>Public Coverage</b>			
Under 100% of FPL	24.10%	24.23%	24.91%
100%-200% of FPL	11.48%	12.11%	15.28%
200%-300% of FPL	4.25%	4.61%	6.41%
300%-400% of FPL	1.90%	2.00%	2.50%
Over 400% of FPL	0.92%	0.91%	0.88%
Total	7.18%	7.38%	8.34%
<b>Uninsured</b>			
Under 100% of FPL	40.34%	40.44%	40.97%
100%-200% of FPL	35.81%	36.39%	39.28%
200%-300% of FPL	21.27%	21.89%	25.01%
300%-400% of FPL	13.16%	13.90%	17.57%
Over 400% of FPL	6.27%	6.43%	7.24%
Total	20.0%	20.2%	22.1%
<b>Private Coverage</b>			
Under 100% of FPL	13.29%	13.22%	12.83%
100%-200% of FPL	13.49%	13.25%	12.06%
200%-300% of FPL	10.45%	10.46%	10.51%
300%-400% of FPL	8.28%	8.43%	9.17%
Over 400% of FPL	7.02%	7.30%	8.67%
Total	9.81%	9.88%	10.24%

SOURCE: ANALYSIS USING MARCH CPS AND KFF/HRET EMPLOYER HEALTH BENEFITS SURVEY

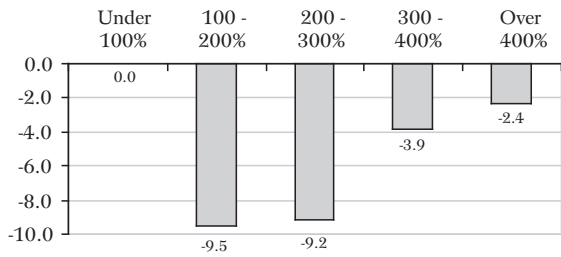
expected population growth, nearly three million more children will be enrolled in a public program and almost two million more will be uninsured, and one and a half million fewer children will be insured through a parent's employer (Chart 32 and 33).

**CHART 29: PAST AND PREDICTED COVERAGE TRENDS FOR ALL U.S. CHILDREN BELOW 300% OF FPL**



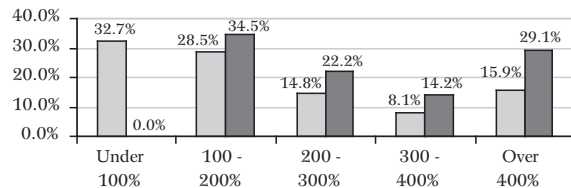
SOURCE: ANALYSIS USING MARCH CPS AND KFF/HRET EMPLOYER HEALTH BENEFITS SURVEY

**CHART 30: PREDICTED REDUCTION IN JOB-BASED COVERAGE, U.S. CHILDREN**



SOURCE: ANALYSIS USING MARCH CPS AND KFF/HRET EMPLOYER HEALTH BENEFITS SURVEY

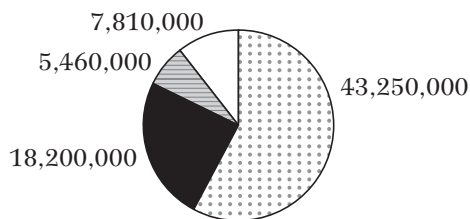
**CHART 31: CURRENT AND NEWLY UNINSURED U.S. CHILDREN**



SOURCE: ANALYSIS USING MARCH CPS AND KFF/HRET EMPLOYER HEALTH BENEFITS SURVEY

Legend: Current Uninsured (light gray), Newly Uninsured (dark gray)

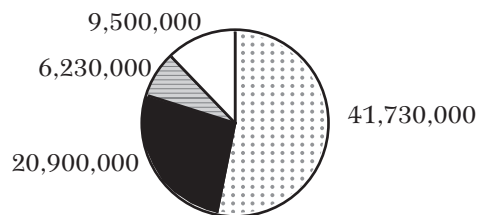
**CHART 32: HEALTH COVERAGE FOR ALL U.S. CHILDREN, 2004**



SOURCE: ANALYSIS USING MARCH CPS AND KFF/HRET EMPLOYER HEALTH BENEFITS SURVEY

Legend: Employer-Based (dotted), Public (solid black), Private (horizontal lines), Uninsured (white)

**CHART 33: PREDICTED HEALTH COVERAGE FOR ALL U.S. CHILDREN, 2010**



**TABLE 15: PAST AND PREDICTED HEALTH COVERAGE FOR ALL U.S. CHILDREN, 2004-2010**

FPL	2004	2005*	2010*
<b>Employer-Based Coverage</b>			
Under 100% of FPL	12.3%	12.3%	12.3%
100%-200% of FPL	41.6%	40.0%	32.1%
200%-300% of FPL	70.0%	68.4%	60.8%
300%-400% of FPL	82.0%	81.4%	78.1%
Over 400% of FPL	87.2%	86.8%	84.9%
Total	60.1%	59.3%	55.3%
<b>Public Coverage</b>			
Under 100% of FPL	65.7%	65.7%	65.7%
100%-200% of FPL	39.4%	40.4%	45.8%
200%-300% of FPL	16.6%	17.7%	23.1%
300%-400% of FPL	6.9%	6.9%	6.6%
Over 400% of FPL	3.4%	3.4%	3.3%
Total	25.3%	25.7%	27.7%
<b>Uninsured</b>			
Under 100% of FPL	19.3%	19.3%	19.5%
100%-200% of FPL	17.4%	18.0%	20.9%
200%-300% of FPL	9.3%	9.7%	11.7%
300%-400% of FPL	6.2%	6.5%	8.0%
Over 400% of FPL	4.0%	4.2%	5.2%
Total	10.8%	11.1%	12.6%
<b>Private Coverage</b>			
Under 100% of FPL	6.1%	6.1%	6.1%
100%-200% of FPL	8.1%	8.0%	7.7%
200%-300% of FPL	9.0%	9.0%	9.3%
300%-400% of FPL	7.5%	7.9%	9.9%
Over 400% of FPL	7.4%	7.6%	8.7%
Total	7.6%	7.7%	8.2%
SOURCE: ANALYSIS USING MARCH CPS AND KFF/HRET EMPLOYER HEALTH BENEFITS SURVEY			

## HEALTH CARE COVERAGE PROJECTIONS FOR CALIFORNIA

### A. The Effect of Increasing Premiums on Coverage Rates in California

To estimate the impact of higher premiums on California families, we simulated price increases based on our national-level regression estimates for the California sub-sample in 2004. This method ensures that the predicted coverage rates account for California’s demographics and job composition; and that the coverage responses account for California’s public health program eligibility rules. Similar to the national findings, the simulation model predicts the effect of a 10% annual premium increase on employer-based coverage, public coverage, private coverage and the uninsurance rate of the state’s non-elderly population.

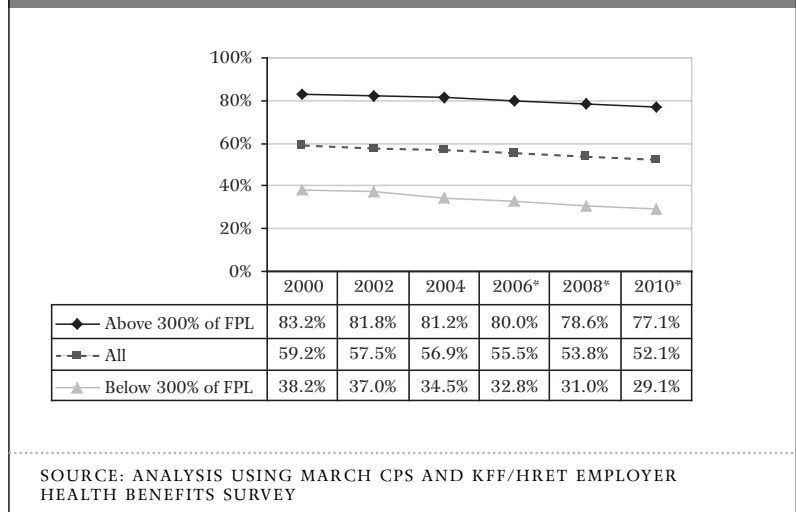
### B. Predictions for All Non-Elderly Californians

Between 2004 and 2010, non-elderly individuals in California are likely to experience a decline in employer-based coverage and a moderate rise in uninsurance. With 10% annual premium increases, as Charts 34 and 35 demonstrate, overall job-based coverage for all non-elderly individuals in California is projected to decline from 57% in 2004 to 52% in 2010, a drop of five percentage points over six years. The proportion of non-elderly Californians who are uninsured is predicted to rise by three percentage points over this period, climbing to 23% by 2010 (Chart 35 on page 38).

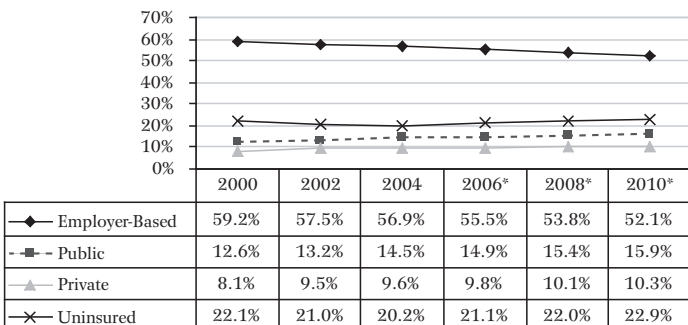
As with the predictions for the nation as a whole, in California the decline in job-based coverage will have the impact on low-to-middle income individuals. By 2010, more non-elderly individuals in California with incomes below the approximate median (300% of FPL) will be uninsured than receive job-based health care, a reversal since 2000 (see Chart 36). Also in line with the national findings, the sharpest decreases in job-based coverage will occur for those in the 100% to 400% of FPL categories. While coverage is expected to decline by less than four percentage points for those over 400% of FPL, and less than one percentage point for those under 100% of FPL, those in the middle will see declines ranging from nearly seven to as much as nine percentage points between 2004 and 2010 (Table 16 on page 40).

The biggest difference between the national find-

**CHART 34: PAST AND PREDICTED JOB-BASED COVERAGE TRENDS FOR ALL NON-ELDERLY IN CALIFORNIA**

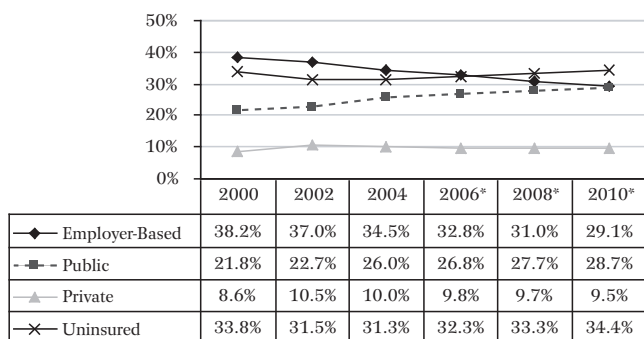


**CHART 35: PAST AND PREDICTED COVERAGE TRENDS FOR ALL NON-ELDERLY IN CALIFORNIA**



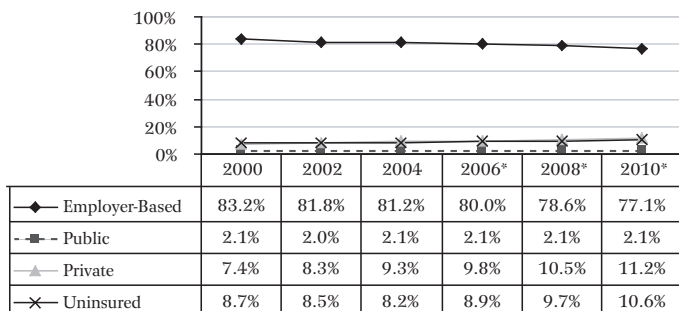
SOURCE: ANALYSIS USING MARCH CPS AND KFF/HRET EMPLOYER HEALTH BENEFITS SURVEY

**CHART 36: PAST AND PREDICTED COVERAGE TRENDS FOR ALL NON-ELDERLY CALIFORNIANS BELOW 300% OF FPL**



SOURCE: ANALYSIS USING MARCH CPS AND KFF/HRET EMPLOYER HEALTH BENEFITS SURVEY

**CHART 37: PAST AND PREDICTED COVERAGE TRENDS FOR ALL CALIFORNIANS ABOVE 300% OF FPL**



SOURCE: ANALYSIS USING MARCH CPS AND KFF/HRET EMPLOYER HEALTH BENEFITS SURVEY

ings and those for California is not in the trends, which are the same, but in the percentage of people predicted to have coverage, which in California will be significantly lower than the national level (predicted job-based coverage of 59% nationally, versus only 52% in California by 2010).

Unsurprisingly, for those between 100% and 300% of FPL, the rise in public insurance will offset part of the fall in employment-based coverage. Given the projected change in public coverage, 39% of individuals below 100% of FPL, 29% between 100% and 200% of FPL, and 14% between 200% and 300% of FPL will be enrolled in a public health insurance program in California by 2010 (Table 16 on page 40).

For families between 300% and 400% of FPL, job-based coverage will fall nearly seven percentage points, a substantial amount (Table 16 on page 40). However, given public program eligibilities, public coverage will not be available to offset the drop in job-based insurance. As a consequence, the uninsurance rate is predicted to rise most sharply for this Californians in this income bracket, by over five percentage points. There will also be a small offset from private coverage, which will rise by one percentage point.

Finally, for individuals above 400% of FPL, the model predicts a much smaller drop in employment-based coverage (3.4 percentage points). Additionally, a relatively smaller share of this drop is translated into uninsurance, which rises by just over one percent points. For this higher-income group, private insurance is predicted to rise by two percentage

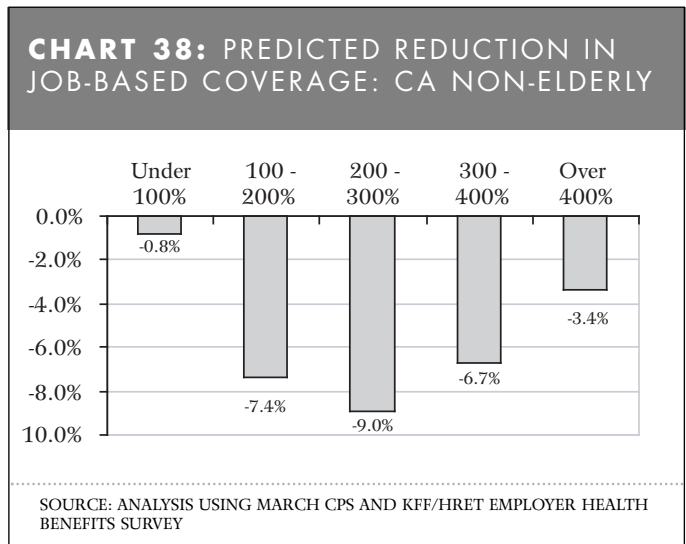


points, offsetting most of the decline in job-based coverage.

Based on our simulation results we can project the number of non-elderly individuals who will be covered by different health insurance programs in 2010. Over the next six years, California's population is projected to grow from 32.2 million in 2004 to 34.8 million in 2010. Taking into account population growth, and given a 10% increase in health care premiums, 170,000 fewer individuals will be insured through an employer-based plan, 880,000 more will be enrolled in a public program, 410,000 more will be insured through a private plan and one and a half million more will be uninsured (Charts 39 and 40).

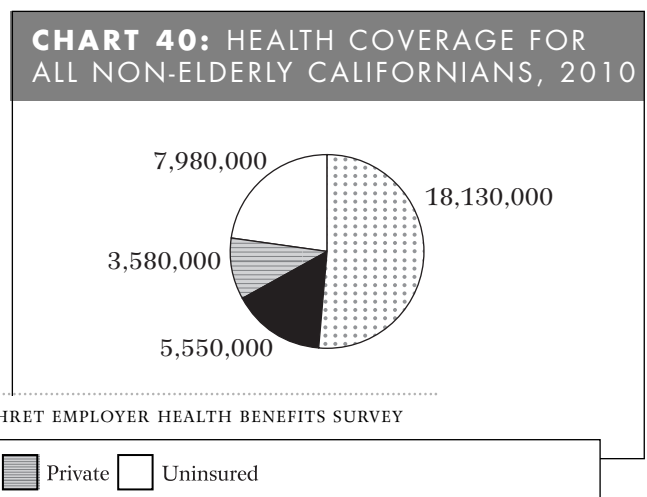
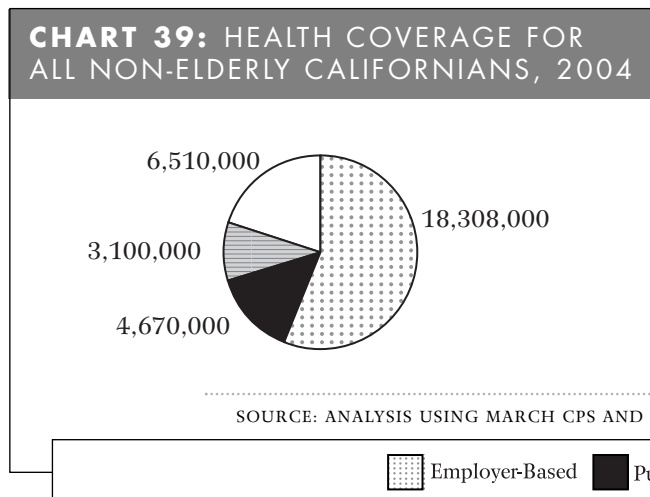
**C. Predictions for California Adults (19-65)**

Coverage trends observed between 2000 and 2004 for adults are predicted to continue through 2010. For all non-elderly adults in California, employer-based coverage will drop another five percentage points, insuring only 53% of the population by 2010 (Chart 41 on page 41). Table 17 and Chart 44 demonstrate that the drop in job-based coverage will be concentrated among adults in families between 100% and 400% of FPL, where coverage will fall by six to eight percentage points. Adults in families above 400% of FPL will have a smaller decline of less than of less than four percentage points, and those under 100% of FPL, only 18% of whom already had



job-based coverage in 2004, will see a decline by one percentage point by 2010. The role of job-based insurance coverage will further diminish for the bottom half of the income distribution; as shown in Chart 42, for adults below 300% of FPL, employer-based insurance will likely cover just 30% of the population by the end of the decade.

Meanwhile, enrollment in a public program is predicted to increase one percentage point by 2010 in the adult population overall, and nearly two percentage points for adults under 300% of FPL. For the latter category, public insurance will cover 18% of individuals by 2010. Overall, uninsurance is projected to increase by three percentage points for all adults



**TABLE 16: PAST AND PREDICTED HEALTH COVERAGE FOR ALL NON-ELDERLY IN CALIFORNIA, 2004-2010**

FPL	2004	2005*	2010*
<b>Employer-Based Coverage</b>			
Under 100% of FPL	18.1%	18.0%	17.3%
100%-200% of FPL	32.5%	31.5%	25.1%
200%-300% of FPL	59.7%	58.6%	50.8%
300%-400% of FPL	74.7%	73.9%	68.0%
Over 400% of FPL	83.2%	82.8%	79.8%
Total	56.9%	56.3%	52.1%
<b>Public Coverage</b>			
Under 100% of FPL	38.2%	38.3%	38.7%
100%-200% of FPL	25.5%	26.0%	29.3%
200%-300% of FPL	9.6%	10.1%	14.2%
300%-400% of FPL	4.2%	4.2%	4.2%
Over 400% of FPL	1.5%	1.5%	1.4%
Total	14.5%	14.7%	16.0%
<b>Uninsured</b>			
Under 100% of FPL	35.2%	35.3%	35.8%
100%-200% of FPL	33.8%	34.1%	38.0%
200%-300% of FPL	23.1%	23.7%	27.5%
300%-400% of FPL	14.2%	14.8%	19.6%
Over 400% of FPL	6.5%	6.6%	7.9%
Total	20.2%	20.6%	22.9%
<b>Private Coverage</b>			
Under 100% of FPL	9.7%	9.6%	9.4%
100%-200% of FPL	10.4%	10.3%	9.5%
200%-300% of FPL	9.8%	9.8%	9.7%
300%-400% of FPL	8.3%	8.5%	9.6%
Over 400% of FPL	9.6%	9.8%	11.6%
Total	9.6%	9.7%	10.3%
SOURCE: ANALYSIS USING MARCH CPS AND KFF/HRET EMPLOYER HEALTH BENEFITS SURVEY			

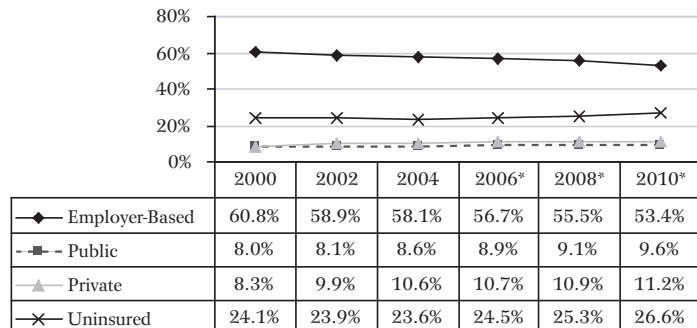
statewide and by nearly four percentage points for adults under 300% of FPL. Uninsurance will rise by a somewhat smaller amount (less than three percentage points) for higher-income adults (those over 300% FPL), as private coverage increases relatively more (two percentage points) to offset the loss in job-based coverage (Chart 43). More detailed breakdowns in Table 15 shows that the increase in uninsurance will be concentrated among adults in the 100% to 400% range of FPL, for whom uninsurance will rise by between five and seven percentage points.

Based on our simulation results and the predicted population growth for California we can estimate the number of adults covered by different health care programs in 2010. In the next six years the adult population is expected to grow from 22.8 million in 2004 to 24.6 million in 2010. Accounting for the projected population growth and assuming health premiums will increase at 10% each year for the next six years, 80,000 fewer adults will be insured through an employer, 400,000 more will be on a public program, 310,000 more will purchase a private plan and one million more will be uninsured by the end of the decade (Chart 45 and 46 on page 42).

### D. Predictions for California Children

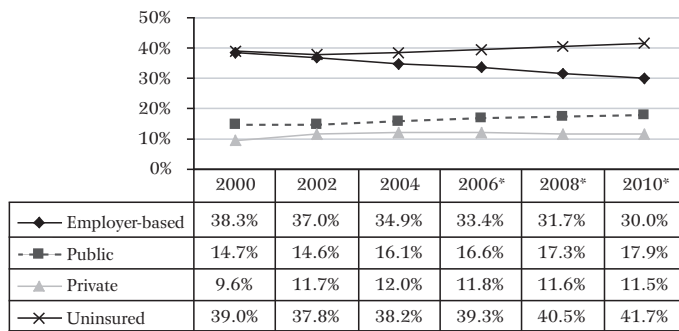
Over this six-year period, employment-based coverage for children is projected to decline five percentage points, insuring fewer than half of the state's children (49%) by 2010 (Chart 47 on page 42). As Chart 48 reports, the drop will

**CHART 41: PAST AND PREDICTED COVERAGE TRENDS FOR ALL ADULTS IN CALIFORNIA**



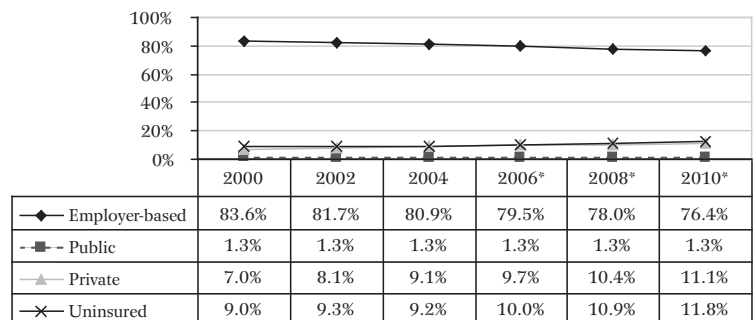
SOURCE: ANALYSIS USING MARCH CPS AND KFF/HRET EMPLOYER HEALTH BENEFITS SURVEY

**CHART 42: PAST AND PREDICTED COVERAGE TRENDS FOR ALL ADULTS BELOW 300% OF FPL IN CALIFORNIA**



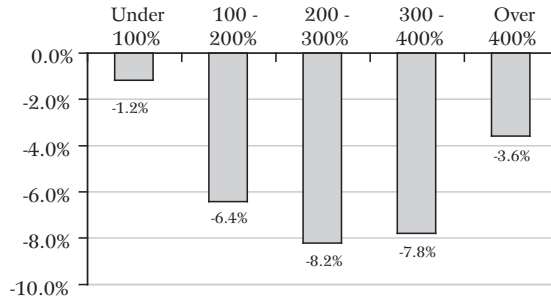
SOURCE: ANALYSIS USING MARCH CPS AND KFF/HRET EMPLOYER HEALTH BENEFITS SURVEY

**CHART 43: PAST AND PREDICTED COVERAGE TRENDS FOR ALL CALIFORNIAN ADULTS ABOVE 300% OF FPL**



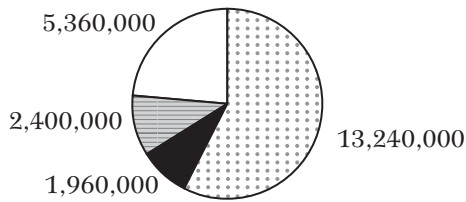
SOURCE: ANALYSIS USING MARCH CPS AND KFF/HRET EMPLOYER HEALTH BENEFITS SURVEY

**CHART 44: PREDICTED REDUCTION IN JOB-BASED COVERAGE: CA ADULTS**

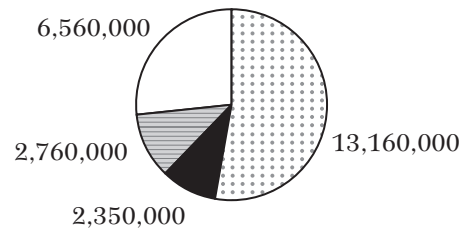


SOURCE: ANALYSIS USING MARCH CPS AND KFF/HRET EMPLOYER HEALTH BENEFITS SURVEY

**CHART 45: HEALTH COVERAGE FOR ALL ADULTS IN CALIFORNIA, 2004**

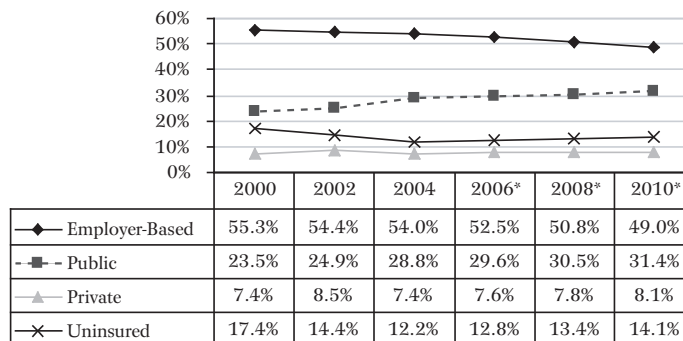


**CHART 46: PREDICTED HEALTH COVERAGE FOR ALL ADULTS IN CALIFORNIA, 2010**



SOURCE: ANALYSIS USING MARCH CPS AND KFF/HRET EMPLOYER HEALTH BENEFITS SURVEY

**CHART 47: PAST AND PREDICTED COVERAGE TRENDS FOR ALL CALIFORNIA CHILDREN**



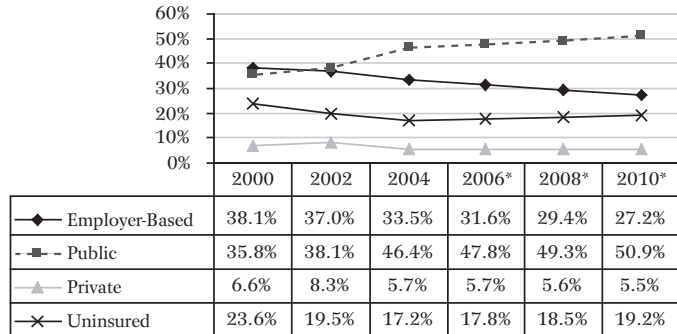
SOURCE: ANALYSIS USING MARCH CPS AND KFF/HRET EMPLOYER HEALTH BENEFITS SURVEY

**TABLE 17: PAST AND PREDICTED ADULT HEALTH COVERAGE IN CALIFORNIA, 2004-2010**

FPL	2004	2005*	2010*
<b>Adult Employer-Based Coverage</b>			
Under 100% of FPL	21.2%	21.0%	20.0%
100%-200% of FPL	32.9%	32.0%	26.5%
200%-300% of FPL	56.9%	55.9%	48.7%
300%-400% of FPL	72.8%	71.9%	65.0%
Over 400% of FPL	83.1%	82.7%	79.5%
<b>Total</b>	<b>58.1%</b>	<b>57.6%</b>	<b>53.4%</b>
<b>Adult Public Coverage</b>			
Under 100% of FPL	24.1%	24.2%	24.9%
100%-200% of FPL	15.5%	15.8%	18.0%
200%-300% of FPL	5.5%	5.8%	8.4%
300%-400% of FPL	2.4%	2.4%	2.5%
Over 400% of FPL	1.0%	1.0%	0.9%
<b>Total</b>	<b>8.6%</b>	<b>8.7%</b>	<b>9.6%</b>
<b>Adult Uninsured</b>			
Under 100% of FPL	43.5%	43.6%	44.3%
100%-200% of FPL	39.7%	40.4%	44.9%
200%-300% of FPL	28.8%	29.5%	34.2%
300%-400% of FPL	17.0%	17.8%	23.8%
Over 400% of FPL	7.1%	7.3%	8.5%
<b>Total</b>	<b>23.6%</b>	<b>24.0%</b>	<b>26.6%</b>
<b>Adult Private Coverage</b>			
Under 100% of FPL	12.1%	12.1%	11.8%
100%-200% of FPL	13.0%	12.9%	11.8%
200%-300% of FPL	10.5%	10.5%	10.4%
300%-400% of FPL	8.6%	8.7%	9.4%
Over 400% of FPL	9.3%	9.5%	11.5%
<b>Total</b>	<b>10.5%</b>	<b>10.6%</b>	<b>11.2%</b>
SOURCE: ANALYSIS USING MARCH CPS AND KFF/HRET EMPLOYER HEALTH BENEFITS SURVEY			

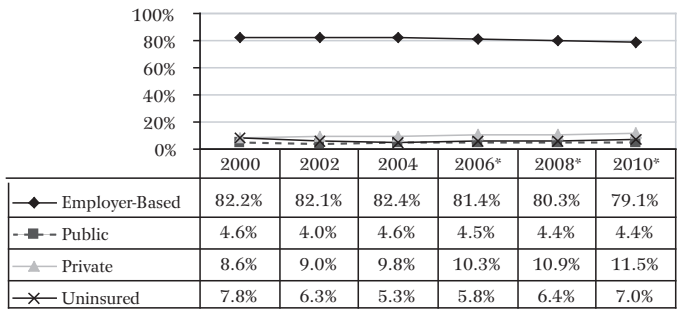
\* Predicted

**CHART 48: PAST AND PREDICTED COVERAGE TRENDS FOR ALL CALIFORNIA CHILDREN IN CALIFORNIA BELOW 300% OF FPL**



SOURCE: ANALYSIS USING MARCH CPS AND KFF/HRET EMPLOYER HEALTH BENEFITS SURVEY

**CHART 49: PAST AND PREDICTED COVERAGE TRENDS FOR ALL CHILDREN IN CALIFORNIA ABOVE 300% OF FPL**



SOURCE: ANALYSIS USING MARCH CPS AND KFF/HRET EMPLOYER HEALTH BENEFITS SURVEY

be more pronounced for those under 300% of FPL, for whom coverage will fall almost seven percentage points to 27%, public coverage will reach half (51%) and uninsurance will rise to 19%.

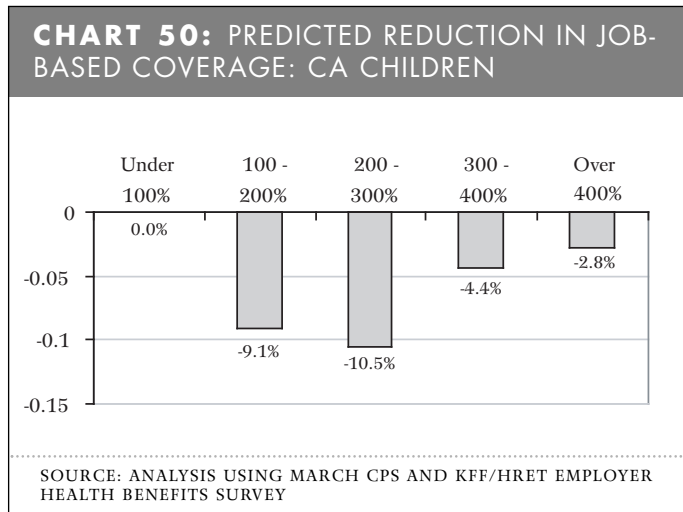
Children whose incomes fall within 100%-300% of FPL will experience the largest decline in job-based coverage (Chart 50). Those in the low-income group of 100-200% of FPL will see declines of over nine percentage points, while those just below the median at 200-300% of FPL will see a drop of well over ten percentage points. California children living below 100% of FPL, nearly 70% of whom had public coverage in 2004 and only 11% of whom received employer-sponsored insurance, will see no decline in job-based coverage. Children with incomes above 400% of FPL will see a modest decline in job-based coverage, almost three percentage points (Table 18 on page 46).

For California children, in contrast to adults, the fall in job-based coverage will result in a sizeable increase in public insurance that will mitigate the growth in uninsurance, since many of the same children between 100% and 300% of FPL who will experience the largest drop in coverage are eligible for a public program. By 2010, approximately 31% of all children in the state and 51% of those below 300% of FPL will be covered by a public program. We also project a small increase (nearly two percentage points) in private insurance for children above 300% of FPL (Chart 49).

At first glance, the projection of rising uninsurance among children may seem at odds with recent trends. However, it

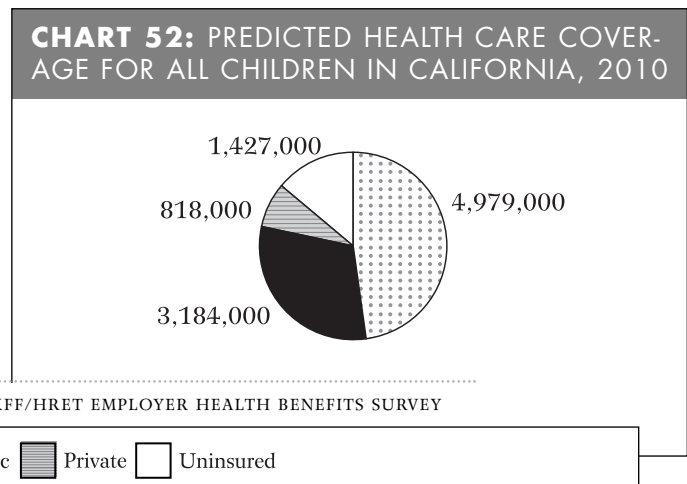
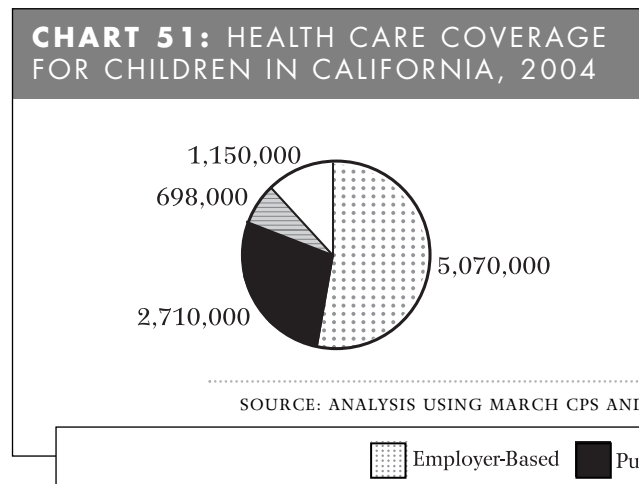
is important to bear in mind that much of the fall in uninsurance occurred through the implementation of SCHIP, which formally began in 1998. This “implementation effect” of increased take-up does not continue indefinitely, and is likely to phase out after the first few years barring expansions in outreach efforts. Consistent with this argument, uninsurance rates among California children in families between 100% and 200% of FPL actually rose between 2002 and 2004 after falling for several years. Therefore, our simulation model assumes that this increased SCHIP take-up among the uninsured—which offset the fall in employer-based coverage in the recent past—will not continue into the future, resulting in a rise in uninsurance. To address this issue, policymakers could devote greater resources to outreach and enrollment of eligible children, which would mitigate the rise in uninsurance projected here.

To estimate the actual number of California children covered by different health insurance programs over the next six years we can use California’s population projections and the results from the simulation model. The total number of children in California is projected to grow from 9.4 million in 2004 to 10.2 million in 2010. Taking into account this projected population growth and given a 10% annual increase in premiums, 90,000 fewer children will be insured through a parent’s employer, 470,000 more will be enrolled in a public program, 290,000 more will be



uninsured and 100,000 more will be enrolled in a private plan by the year 2010 (Charts 51 and 52).

Our simulations for California show that increasing health premiums over time will lead to a major loss of employer-based coverage. As working families lose coverage, they either become uninsured or reliant on a public program. Should current trends continue, public insurance will no longer be a safety net system. Instead, public and job-based coverage each will insure roughly the same number of families (29%) from the lower half of the state’s population in terms of income (those under 300% FPL) by 2010. Meanwhile, the greatest proportion of these lower- and middle-income individuals (36%) will simply go uninsured.



Employer-Based Public Private Uninsured

**TABLE 18: PAST AND PREDICTED CHILDREN'S HEALTH COVERAGE IN CALIFORNIA, 2004-2010**

FPL	2004	2005*	2010*
<b>Children's Employer-Based Coverage</b>			
Under 100% of FPL	11.4%	11.4%	11.4%
100%-200% of FPL	31.8%	30.5%	22.7%
200%-300% of FPL	65.8%	64.5%	55.3%
300%-400% of FPL	79.2%	78.7%	74.8%
Over 400% of FPL	83.5%	83.2%	80.7%
Total	54.0%	53.4%	49.0%
<b>Children's Public Coverage</b>			
Under 100% of FPL	68.8%	68.8%	68.8%
100%-200% of FPL	45.1%	46.0%	51.2%
200%-300% of FPL	18.1%	19.1%	26.3%
300%-400% of FPL	8.5%	8.5%	8.1%
Over 400% of FPL	3.2%	3.1%	3.0%
Total	28.9%	29.2%	31.4%
<b>Children Uninsured</b>			
Under 100% of FPL	17.3%	17.3%	17.3%
100%-200% of FPL	21.3%	21.8%	24.8%
200%-300% of FPL	11.0%	11.4%	13.4%
300%-400% of FPL	7.4%	7.7%	9.7%
Over 400% of FPL	4.5%	4.6%	6.0%
Total	12.2%	12.4%	14.1%
<b>Children's Private Coverage</b>			
Under 100% of FPL	4.3%	4.3%	4.3%
100%-200% of FPL	5.3%	5.3%	4.9%
200%-300% of FPL	8.3%	8.3%	8.3%
300%-400% of FPL	7.5%	7.8%	10.0%
Over 400% of FPL	10.6%	10.8%	12.1%
Total	8.5%	7.5%	8.1%
SOURCE: ANALYSIS USING MARCH CPS AND KFF/HRET EMPLOYER HEALTH BENEFITS SURVEY			

\* Predicted



## POLICY IMPLICATIONS

The continuing drop in job-based health care coverage is an issue of growing concern for working families, legislators and health care advocates. The rate at which job-based health coverage declines with premium growth suggests that unless major policy changes are undertaken now, the employer-based system will no longer provide the central source of health coverage for large sectors of the population. Low- and middle-income families are disproportionately affected by the decline of job-based coverage and proposed solutions must take into account the economic realities of these families.

**Without major policy changes employer-based coverage will continue to erode.**

Our model results indicate that if premiums continue to climb at current rates, nearly half of all non-elderly individuals in California will be cut off from job-based insurance by 2010, almost one-quarter will be uninsured and 16% will rely on a public program. Lower- and middle-income families will especially bear the brunt of cuts to employer-based coverage. Over the next five years, an estimated 29% of individuals in California below 300% of FPL will be enrolled in a public program, 34% will be uninsured and only 29% will receive coverage through their employer. However, even for these families in the top half of income, insurance will fall to 77% by 2010 as premiums continue to rise. These California trends are mirrored nationally. *What used to be a fundamental component of the social contract for American workers across the income spectrum is now becoming a benefit enjoyed primarily by higher-income families.*

**A continued decline in employer-sponsored insurance will shift additional health care costs from employers to the public sector, and increase the numbers of uninsured.**

Faced with large premium increases over the last five years, employers are implementing changes to their benefit packages to reduce health care expenditures. Policies such as shifting additional costs to employees, reducing benefits, or cutting health coverage altogether are forcing employees and their dependents either to enroll in public programs or to rely on the public safety net for health care, signaling a significant cost shift from the private to the public sector. Local, state and federal governments now absorb the financial burden that used to be paid by the employer and the employee. As a result, local and state governments have thus far been unable to absorb the rising costs of health care without cuts to other social programs. *Unless immediate steps are taken to stem the decline in job-based coverage, significant new revenues will be needed to cover the increased demand for public health programs.*

**Proposed federal and state cutbacks to Medicaid and SCHIP will jeopardize coverage for children and low-income adults.**

In response to rising health expenditures, state and federal governments are implementing new policies to curb take-up of public insurance. In the last four years, 49 states have instituted enrollment caps, new eligibility restrictions or cuts in services to reduce costs. In April of 2005, the Congress agreed to non-binding budget language for 2006 that, if implemented, would reduce Medicaid expenditures by \$10 billion over the next five years starting in 2007. In addi-

tion, the Bush administration has proposed to transform Medicaid into a block grant program that would limit the federal government’s risk in absorbing increased costs. Under a block grant, states would receive a fixed amount of federal funding regardless of increases in health costs, jumps in enrollment or changes in economic conditions. This policy would move all future increases in the financial burden onto the states. *Any cuts to public programs will threaten access to coverage for millions of children and low-income adults.*

**Private insurance options are mismatched to those losing coverage.**

For most low- and middle-income families, purchasing individual health insurance at market rate is not an affordable option. Instead, when these families lose employer-based coverage, they will likely opt for a public plan, if eligible, or go without coverage and seek care through the local safety net. The inability of low-to-middle-income families to purchase private health insurance plans indicates that solutions to address the dramatic drop in employer-based coverage among this group must improve access to health insurance without requiring significant out-of-pocket expenses. *Therefore policies that rely on private insurance, such as individual mandates or health savings accounts, are mismatched to the economic reali-*

*ties of those losing insurance today.*

**Children’s health insurance programs work to reduce uninsurance.**

In the last five years, uninsurance among children has declined due to a dramatic increase in the take-up of public programs. Despite a four-percentage point drop in employer-based coverage nationally, public coverage rose six-percentage points, generating a net increase in health insurance for children. Public programs have also dramatically reduced the health disparity gaps among different racial and ethnic groups. Between 2000 and 2004, both Medicaid and SCHIP had a significant impact in reducing children’s health coverage disparities for Latino’s and African Americans. However, continued premium cost increases and reductions in job-based coverage can be expected to translate into both greater use of public programs and a new increase in uninsurance among children, reversing the recent jump in coverage. *A new increase in uninsurance for children could be prevented by expanding public health programs for children through a combination of higher eligibility thresholds, simpler enrollment processes and new outreach efforts.*

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## CONCLUSIONS

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Rapidly rising health care premiums are contributing to the steady erosion of job-based health care coverage in the United States. Along with the decline in employer-based coverage is a shift towards greater use of public health programs by working families, without any clear plans to finance the rising cost. Failure to stem the decline in employer-based coverage will

require significant new public funds that will be needed to absorb the growing number of people without job-based coverage. Efforts by national and state policymakers must address the breakdown in our health care delivery system. Without serious action, America will experience a dramatic increase in the number of uninsured persons by the end of the decade.

**APPENDIX A: TECHNICAL APPENDIX ON METHODOLOGY**

**Data Sources and Definitions**

This section reports the primary data sources and the population analyzed in this study. Here we also define some important categories used throughout the report such as family, types of health coverage, and work status.

This study uses data from the March Supplement to the household-based Current Population Survey (CPS) for the purpose of identifying different types of health insurance coverage. The four primary categories of coverage identified here are employer-based, public (includes Medicaid and State Children’s Health Initiative Programs), and private coverage as well as uninsured. The CPS asks respondents if they were covered by a particular form of health insurance at any time over the previous year (e.g., by an employer-based insurance, or Medicaid). Those are not being covered by one of the various types of insurance are categorized here as uninsured.

The population studied here includes children (those under 19) and non-elderly adults (ages 19-65). Sometimes, results are reported by family characteristics, such as family income. Our definition of a family corresponds to the concept of a health insurance eligibility unit (HIEU). It is composed of adults, their spouses, all children under 18, and children between the ages of 19-23 if they are full-time students.

Family income was computed as total annual income of families as defined here. Relation to the Federal Poverty Level (FPL) was computed

as follows. We computed the poverty level income based on the number and type of family members and the year. Then we computed the ratio of family level income to the FPL. Our family income in relation to FPL differs sometimes from the pre-produced variables in the March CPS due to different definitions of family. Our definition of family more closely resembles the relevant family definition for both job-based and public health insurance, and our definition of family income is closer to what is used to determine eligibility by public programs.

For the purpose of this report, a worker is someone who worked at the time of the interview, and also for at least 45 weeks in the past year; workers are considered to be full-time if they work at least 35 hours a week. As the health coverage questions refer to the year prior to the date of interview, it is important to have a corresponding annual concept of work. A working family is defined as having at least one member of the family (HIEU) working at the time of the interview, and who worked at least 45 weeks in the past year. Finally, a full-time working family is defined as having at least one member of the family working at the time of the interview, who works at least 35 hours a week and has worked at least 45 weeks in the past year.

Although the CPS has information on health coverage, it does not contain data on health insurance premiums. Therefore, the CPS data is augmented by information on premium costs of job-based plans from the Kaiser Family

TABLE A1: FEDERAL POVERTY INCOME LEVELS				
Federal Poverty Income Levels				
Year	Number of Adults	Number of Children	Income at 100% of FPL	Income at 300% of FPL
2000	1	0	\$8,959	\$26,877
2000	1	1	\$11,869	\$35,607
2000	1	2	\$13,874	\$41,622
2000	2	2	\$17,463	\$52,389
2000	2	3	\$20,550	\$61,650
2003	1	0	\$9,573	\$28,719
2003	1	1	\$12,682	\$38,046
2003	1	2	\$14,824	\$44,472
2003	2	2	\$18,660	\$55,980
2003	2	3	\$21,959	\$65,877
Percent of Individuals at or Below 300% of FPL				
California		United States		
53.4%		50.3%		
52.9%		49.2%		
54.2%		49.9%		
52.6%		50.3%		
52.0%		50.6%		

Foundation / Health Research and Educational Trust Employer Health Benefits Survey. We estimate the average single and family premium by region (i.e., 8 census divisions, the most disaggregated geographic identifiers available in the data) for each year, and match this to the CPS survey. We form two region-specific premium indices – for single and family plans – by dividing the premium in year  $t$  over the premium in year 2000. Formally, the premium price indices are:

$$(0.1) \quad P_{jt}^F = \frac{\text{premium}_{jt}^{\text{Family}}}{\text{premium}_{j2000}^{\text{Family}}}, \quad P_{jt}^S = \frac{\text{premium}_{jt}^{\text{Single}}}{\text{premium}_{j2000}^{\text{Single}}}$$

Here  $j$  refers to one of 8 census divisions. The construction of the premium price indices and the fact that we include state dummies in our regressions

imply that we only use *intertemporal* variation in prices over this period by region, as opposed to variation in the level of prices across regions, to estimate how the coverage rate changes in response to increased premium prices. There is substantial variation in premium price growth among the 8 regions. The family premium index  $P_{jt}^F$  ranges between 1.45 and 1.64, meaning the aggregate growth in premium prices varies between 45% and 64% depending on the region. Similarly, the single premium index  $P_{j2000}^S$  ranges between 1.33 and 1.59. This regional variation in price growth means that we are not identifying coverage responses solely from a common national time trend.

Below we report average premium prices for US and California over this period.

**TABLE A2: AVERAGE ANNUAL PREMIUM AND WORKER CONTRIBUTION**

Year	Average Annual Family Premium	Average Worker Contribution	Average Annual Individual Premium	Average Worker Contribution
<b>US</b>				
2000	\$6,567	\$1,670	\$2,557	\$259
2001	\$6,603	\$2,022	\$2,710	\$288
2002	\$7,695	\$2,308	\$3,213	\$439
2003	\$8,760	\$2,621	\$3,418	\$364
2004	\$9,831	\$3,156	\$3,862	\$576
<b>CA</b>				
2000	\$5,890	\$1,477	\$2,267	\$271
2001	\$6,273	\$1,536	\$2,348	\$306
2002	\$7,361	\$1,923	\$2,796	\$376
2003	\$8,422	\$2,552	\$3,048	\$454

SOURCE: KAISER FAMILY FOUNDATION, EMPLOYER HEALTH BENEFIT SURVEY

**Regression Specification**

We estimate the coverage responses separately for four types of individuals: (1) working individuals without a working spouse; (2) working individuals with a working spouse; (3) non-working individual with a working spouse; and (4) child with at least one working parent. Such disaggregation allows the effect of premiums on coverage to vary based on work status and availability of spousal coverage. Moreover, it ensures that changes in working family compositions over this period (e.g., less workers because of the economic downturn) does not confound the impact of prices on coverage. The outcome variables in all cases are: (1) employment-based coverage - either own or dependent; (2) public coverage through Medicaid or SCHIP (for children); (3) private coverage; (4) uninsured.

To quantify the premium responses, we use a multinomial logit model, which jointly estimates the probabilities of having employer, public and private coverage as well as the probability of being uninsured. The primary independent variable is the premium price index

- single plan premium for workers, and family plan for dependent adults and children. This premium price index,  $P$ , is interacted with five categories of family income: under 100% of FPL, 100-199% of FPL, 200-299% of FPL, 300-399% of FPL, and 400% of FPL and over, *each in turn interacted with an individual level public eligibility indicator*. This is a 0-1 variable indicating public program eligibility, which is coded for each person using state, income and age-specific eligibility rules for Medicaid and SCHIP over this period.<sup>1</sup> Overall, the set of interactions produce a total of ten premium cost variables, and ten sets of family income variables crossed with public eligibility. This set of twenty variables can be represented as follows:

$$(0.2) \quad \left\{ \prod_{j=0}^4 \prod_{k=0}^1 FPL_j \cdot Elig_k \right\} U \left\{ \prod_{j=0}^4 \prod_{k=0}^1 FPL_j \cdot Elig_k \cdot P \right\}$$

$FPL$  is the five-category family income variable described above.  $Elig$  is a dummy variable indicating public program eligibility. And  $P$  is the premium cost index as defined in Equation (0.1).

Intuitively, this formulation allows the coverage

response of a child in a family with 275% of FPL to vary if that child lives in a state where she is eligible for SCHIP versus a state where is not. Since we are only imperfectly able to tell whether an individual would be eligible based on family income information, we leave out “near eligible” individuals - within 25% of the cutoff in each state - from our regression estimation. However, this does not substantially change any of the results.

**Regression Specification for Working Adults**

The regression model controls for demographic factors such as age, gender, race (Latino, African American, Asian, and other), education levels (high school and college graduation), the number of year round workers in the family, industry and job characteristics, as well as a state dummy. Job characteristics include: 1-digit level industry, 6 categories of firm size, whether the individual is self-employed, whether the individual is working full time, and whether the individual has been at the same job for the past year. This control helps net out changes in coverage that are due to changing observable job characteristics over this period, as opposed to premium increases. In the specification below, *Demog* is a vector of demographic variables, *Ind* is a vector of industry dummies and *FirmSize* is a vector of firm size dummies.

$$Y^H = \beta_0^H + \left\{ \sum_{j=0}^4 \sum_{k=0}^1 \gamma_{jk}^H \cdot FPL_j \cdot Elig_k \right\} + \left\{ \sum_{j=0}^4 \sum_{k=0}^1 \delta_{jk}^H \cdot FPL_j \cdot Elig_k \cdot P^s \right\} + \Omega^H State + \Lambda^H Demog + \Phi^H Ind + \Gamma^H FirmSize + \eta_1^H SelfEmp + \eta_2^H FullTime + \eta_3^H SameJob + \varepsilon$$

(0.3)

The multinomial logit produces 3 sets of coefficients (represented by the superscript H), each corresponding to one of three types of outcome categories (public coverage, private coverage, or uninsurance) as compared to the base category (job-based coverage). The primary coefficients of interest are the price responses  $\delta_{jk}^H$ . As an example, represents the increased odds of uninsurance (vis-à-vis  $\delta_{jk}^{uninsurance}$  employment based coverage) resulting from an increase in the single premium price index – for workers in families between 100% and 200% of FPL in states where such workers are ineligible for public coverage.

The regression is estimated separately for working adults with and without working spouses.

**Regression Specification for Adult Dependents**

For adult dependents – i.e., non-working spouses of working individuals – a similar model is fitted. The

$$Y^H = \beta_0^H + \left\{ \sum_{j=0}^4 \sum_{k=0}^1 \gamma_{jk}^H \cdot FPL_j \cdot Elig_k \right\} + \left\{ \sum_{j=0}^4 \sum_{k=0}^1 \delta_{jk}^H \cdot FPL_j \cdot Elig_k \cdot P^s \right\} + \Omega^H State + \Lambda^H Demog + \Phi^H Ind + \Gamma^H FirmSize + \eta_1^H SelfEmp + \eta_2^H FullTime + \eta_3^H SameJob + \varepsilon$$

regression specification is as follows.

(0.4)

There are two differences between (0.3) and (0.4). First, in the specification for dependents, we use the family instead of single premium index. Second, the job characteristics in (0.4) refer to those of the working spouse, and are denoted as *Ind* as opposed to *Ind*.

**Regression Specification for Dependent Children**

Within our definition of family, an adult could only have one person (a working spouse) who could claim him as a dependent. However, a child may have two working parents who can claim her as a dependent; in such a case, we need to consider the job characteristics of both individuals. We deal with this issue by taking the parent whose characteristics *maximizes* the odds of having employment-based coverage, and using this in the children’s regression. These characteristics were estimated as follows: (1) a first level OLS regression is run for each working parent predicting job-based coverage as a function of the job characteristics (industry, firm size, self-employment, full-time work and having worked at the same job over the past year, high school and college completion); and (2) taking the job characteristics of the working parent who has the *maximum* predicted odds of having employment-based coverage. The regression specification is as follows, with the terms with hats referring to the job characteristics of the relevant working parent.

For the children’s regression, there is an additional concern. Over this period, most states began implementing State Children’s Health Insurance Programs

(SCHIP). The SCHIP was created to build on Medicaid program and provide health insurance to children who cannot access employer-based coverage and are ineligible for Medicaid. Since its creation in 1997, virtually every state has taken steps to extend health coverage to low-income children (and in some states to parents), and by 2003 more than 7.1 million individuals were enrolled in SCHIP. Eligibility for SCHIP also varies by state, and in California children up to 250% of FPL are eligible for either Medi-Cal or SCHIP.

Take-up of such programs usually occurs over the first few years of implementation as outreach and enrollment efforts are conducted. This fact introduces a possible bias as we use intertemporal variation in premium costs to identify how coverage responds to costs. The “one time” increase in public coverage and reduction in uninsurance (what we call “implementation effect”) can confound our estimates. To address this issue, we use a “difference in difference” strategy by estimating the children’s regression for working and non-working families, and including a time variable allowing trends in take-up of public coverage (vis-à-vis uninsurance and private coverage). This specification estimates the implementation effect of increased public coverage and reduced uninsurance by taking as a control group a population not affect-

Formally, (0.5) uses “public coverage” as the base category. For all non-working family children,  $FPL_j \cdot Elig_j \cdot P$  is set at zero, since they cannot be affected by rising job-based premiums. A common time trend is fitted for working and non-working family children in determining the odds of uninsurance and private coverage – vis-à-vis public coverage. (Such a trend cannot be included for employment versus public coverage, as by definition, this group does not have a benchmark among the non-working family population.) For these children, separate “industry,” “firm size” and other job categories are created, as by definition there are no workers in the family. Common coefficients are estimated for working and non-working children for the following: demographic variables, state dummies, and the time trend.

**Regression Estimates**

Below we report the coefficients and standard errors from the four key regressions estimated using multinomial logit models. The regression coefficients are presented in terms of relative risk ratios – which can be interpreted as how an incremental change in the independent variable affects the relative odds of an outcome  $O$  as compared to the “base outcome.” The base outcome is employment-based coverage for the three adult regressions. Since we need to control for time-specific trends for public coverage due to the implementation effect of SCHIP, the base category for children’s regression is public coverage. We do not report the coefficients associated with state, industry, family size and firm-size dummies below.

**Coverage Responses to a 10% Increase in Premium**

Since the coefficients (even the relative risk ratios terms) of a multinomial logit are not as easily interpretable as changes in probabilities, the table below reports the coverage responses to a 10% increase in premium by type of individual (workers, dependent adults and children) and income levels, estimated for the U.S. working family population. Coefficients that are statistically significant at 5% level are marked with an asterisk (\*).

All else equal, for all non-elderly adults, a 10%

$$p^H = \begin{cases} \beta_0^H + \beta_1^H WorkingFam + \beta_2^H Time + \left\{ \sum_{j=0}^4 \gamma_j^H \cdot FPL_j \cdot Elig_j \right\} + \left\{ \sum_{k=0}^4 \delta_k^H \cdot FPL_k \cdot Elig_k \cdot P^k \right\} \\ + \Omega^H State + \Lambda^H Demog + \Phi^H Ind + \Gamma^H FirmSize + \eta_1^H SelfEmp + \eta_2^H FullTime + \eta_3^H SameJob + \varepsilon \\ \text{if } H \in \{uninsured, private\} \\ \\ \beta_0^H + \beta_1^H WorkingFam + \left\{ \sum_{j=0}^4 \gamma_j^H \cdot FPL_j \cdot Elig_j \right\} + \left\{ \sum_{k=0}^4 \delta_k^H \cdot FPL_k \cdot Elig_k \cdot P^k \right\} \\ + \Omega^H State + \Lambda^H Demog + \Phi^H Ind + \Gamma^H FirmSize + \eta_1^H SelfEmp + \eta_2^H FullTime + \eta_3^H SameJob + \varepsilon \\ \text{if } H \in \{employment based\} \end{cases}$$

ed by rising costs of job-based insurance: the children of non-working families. Consequently, the premium effects are estimated net of such implementation effects. For our future simulation, we do not forecast continuation of this implementation effect.

(0.5)



**TABLE A3: COEFFICIENTS FROM MULTINOMIAL LOGIT REGRESSIONS FOR HEALTH INSURANCE**

Adults with Working Spouse	Public		Private		Uninsurance	
	Coefficient (RRR)	Std. Error	Coefficient (RRR)	Std. Error	Coefficient (RRR)	Std. Error
100-199% FPL	0.297	0.378	0.453	0.862	0.548	0.679
200-299% FPL	0.366	0.245	0.356	1.073	0.391	0.856
> 400% FPL	0.154	0.251	2.308	4.033	1.675	2.058
Not Public Elig	0.426	0.384	0.214	0.459	0.097	0.150
100-199% FPL * Not Public Elig	1.527	2.416	7.701	19.931	7.106	12.157
200-299% FPL * Not Public Elig	0.324	0.610	6.362	22.080	8.415	20.937
300-399% FPL * Not Public Elig	0.145	0.256	3.162	5.586	1.812	2.250
Premium	1.007	0.006	1.011	0.010	1.006	0.008
Premium * Not Public Elig	1.007	0.006	1.006	0.017	1.018	0.012
Premium * 100-199% FPL	1.005	0.010	0.995	0.014	0.998	0.010
Premium * 100-199% FPL * Not Public Elig	0.988	0.011	0.993	0.020	0.986	0.013
Premium * 200-299% FPL	0.993	0.003	0.997	0.022	0.996	0.016
Premium * 200-299% FPL * Not Public Elig	1.003	0.014	0.990	0.025	0.984	0.018
Premium * 300-399% FPL	0.990	0.013	0.984	0.013	0.981	0.009
Premium * >400% FPL	0.985	0.012	0.985	0.013	0.979	0.009
Age	0.957	0.005	1.006	0.002	0.994	0.002
Female	1.292	0.128	1.112	0.048	1.178	0.037
Black	2.322	0.317	0.847	0.078	1.522	0.078
Latino	1.276	0.179	0.811	0.065	2.230	0.093
Asian	1.841	0.361	1.476	0.130	2.264	0.140
High School Graduate	0.599	0.070	0.836	0.062	0.576	0.023
Bachelors Degree	0.624	0.078	0.885	0.040	0.717	0.027
Not Self-Employed	0.897	0.133	0.306	0.016	0.698	0.030
Full Time	0.626	0.062	0.613	0.027	0.843	0.030
Same Job >1 year	1.196	0.182	0.859	0.057	0.849	0.040
<b>Working Adult without Working Spouse</b>	<b>Public</b>	<b>Private</b>	<b>Uninsurance</b>			
	<b>Coefficient (RRR)</b>	<b>Std. Error</b>	<b>Coefficient (RRR)</b>	<b>Std. Error</b>	<b>Coefficient (RRR)</b>	<b>Std. Error</b>
100-199% FPL	0.205	0.092	0.333	0.210	0.479	0.184
200-299% FPL	0.498	0.203	0.512	1.190	0.769	1.415
300-399% FPL	0.130	0.068	0.230	0.081	0.177	0.043
> 400% FPL	0.215	0.069	0.167	0.053	0.194	0.045
Not Public Elig	0.334	0.057	0.808	0.386	0.972	0.292
100-199% FPL * Not Public Elig	2.323	1.172	3.313	2.339	1.470	0.639
200-299% FPL * Not Public Elig	0.468	0.315	0.705	1.654	0.486	0.899
Premium	1.003	0.001	0.996	0.003	1.000	0.002

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Premium * Not Public Elig	1.003	0.001	1.004	0.004	1.002	0.002
Premium * 100%-199% FPL	1.009	0.003	1.008	0.005	1.003	0.003
Premium * 100%-199% FPL * Not Public Elig	0.992	0.004	0.989	0.005	0.997	0.003
Premium * 200%-299% FPL	0.998	0.002	1.001	0.017	0.994	0.014
Premium * 200%-299% FPL * Not Public Elig	1.003	0.004	1.000	0.017	1.006	0.014
Premium* 300%-399% FPL	1.001	0.004	1.003	0.003	1.002	0.002
Premium* >400% FPL	0.994	0.002	1.005	0.002	0.998	0.002
Age	0.987	0.001	0.992	0.001	0.980	0.001
Female	1.514	0.057	1.137	0.029	0.939	0.016
Black	2.000	0.099	0.810	0.036	1.631	0.040
Latino	1.287	0.069	0.742	0.034	1.925	0.044
Asian	1.642	0.142	1.134	0.068	1.762	0.069
High School Graduate	0.444	0.020	1.017	0.046	0.520	0.012
Bachelors Degree	0.464	0.028	0.918	0.026	0.670	0.015
Not Self-Employed	0.683	0.050	0.304	0.011	0.584	0.017
Full Time	0.497	0.019	0.410	0.011	0.666	0.013
Same Job >1 year	0.760	0.036	0.686	0.022	0.810	0.018
<b>Non-Working (Dependent) Adults with Working Spouse</b>	<b>Public</b>		<b>Private</b>		<b>Uninsurance</b>	
	<b>Coefficient (RRR)</b>	<b>Std. Error</b>	<b>Coefficient (RRR)</b>	<b>Std. Error</b>	<b>Coefficient (RRR)</b>	<b>Std. Error</b>
100-199% FPL	0.121	0.065	0.078	0.071	0.321	0.160
200-299% FPL	0.387	0.143	0.086	0.189	2.176	4.428
300-399% FPL	0.291	0.183	0.255	0.187	0.371	0.177
> 400% FPL	0.183	0.096	0.221	0.156	0.267	0.122
Not Public Elig	0.304	0.085	0.269	0.236	0.204	0.102
100-199% FPL * Not Public Elig	4.637	2.794	9.396	10.842	3.047	1.970
200-299% FPL * Not Public Elig	0.640	0.491	7.461	17.184	0.201	0.418
Premium	1.004	0.002	0.992	0.004	1.000	0.003
Premium * Not Public Elig	1.004	0.002	1.008	0.007	1.010	0.004
Premium * 100%-199% FPL	1.010	0.004	1.015	0.007	1.002	0.004
Premium * 100%-199% FPL * Not Public Elig	0.989	0.004	0.984	0.009	0.992	0.005
Premium * 200%-299% FPL	0.996	0.002	1.014	0.016	0.981	0.015
Premium * 200%-299% FPL * Not Public Elig	1.003	0.005	0.985	0.017	1.014	0.016
Premium* 300%-399% FPL	0.995	0.005	1.004	0.006	0.993	0.004
Premium* >400% FPL	0.993	0.004	1.004	0.005	0.992	0.003
Age	0.986	0.002	1.010	0.001	1.001	0.001
Female	0.837	0.038	0.576	0.020	0.890	0.026
Black	1.928	0.131	1.147	0.074	1.541	0.075
Latino	1.244	0.071	0.710	0.041	2.256	0.077
Asian	1.474	0.140	1.065	0.085	1.844	0.106
High School Graduate	0.595	0.026	0.853	0.038	0.635	0.019
Bachelors Degree	0.385	0.028	0.761	0.030	0.646	0.023
Not Self-Employed	1.133	0.093	0.395	0.020	0.847	0.040
Full Time	0.617	0.034	0.618	0.027	0.780	0.030
Same Job >1 year	0.608	0.038	0.747	0.042	0.793	0.035

Children	Employment		Private		Uninsurance	
	Coefficient (RRR)	Std. Error	Coefficient (RRR)	Std. Error	Coefficient (RRR)	Std. Error
Year	.	.	0.950	0.008	0.920	0.006
Working Family Member	2.757	0.410	1.231	0.220	1.702	0.220
<100% FPL	0.314	0.013	0.557	0.025	0.341	0.010
100-199% FPL	1.803	0.078	1.388	0.074	0.407	0.013
200-299% FPL	5.221	0.525	3.263	0.427	0.744	0.095
300-399% FPL	8.676	0.440	3.354	0.302	0.610	0.061
> 400% FPL	15.038	0.721	5.412	0.414	0.761	0.068
100-199% FPL * Not Public Elig	1.686	0.706	2.819	1.273	1.444	0.637
200-299% FPL * Not Public Elig	2.084	0.307	1.644	0.297	1.399	0.263
Premium * 100%-199% FPL	0.995	0.000	0.998	0.000	1.000	0.002
Premium * 100%-199% FPL * Not Public Elig	1.002	0.004	0.997	0.005	1.002	0.005
Premium * 200%-299% FPL	0.995	0.001	0.996	0.001	0.998	0.001
Premium * 200%-299% FPL * Not Public Elig	0.999	0.001	1.000	0.001	1.000	0.002
Premium* 300%-399% FPL	1.000	0.001	1.003	0.001	1.003	0.001
Premium* >400% FPL	1.001	0.001	1.002	0.001	1.003	0.001
Age	1.020	0.002	1.057	0.002	1.041	0.002
Female	1.008	0.016	1.034	0.023	0.999	0.017
Black	0.526	0.014	0.400	0.015	0.813	0.021
Latino	0.514	0.012	0.326	0.012	1.221	0.028
Asian	0.758	0.037	0.662	0.044	1.315	0.067
High School Graduate	1.831	0.366	1.396	0.233	1.434	0.422
Bachelors Degree	2.358	0.323	1.419	0.177	1.980	0.388
Not Self-Employed	0.956	0.045	0.442	0.023	0.783	0.037
Full Time	1.659	0.051	0.881	0.036	1.202	0.043
Same Job >1 year	1.636	0.058	1.131	0.057	1.267	0.054

increase in premium results in a 0.5 percent point decline in employer-based coverage. Of this loss, more than half (0.27 percent point) is absorbed through increased uninsurance, and a lesser extent (0.17 percent point) through public coverage. The fall in employer-sponsored coverage is much greater (more than twice) for individuals in the 100% to 400% of FPL categories than for either individuals under the poverty line, or individuals with incomes greater than 400% of FPL.

**Comparison to Other Estimates in the Literature**

Several other studies have also recently estimated the impact of premium costs on health coverage – be they employer-based coverage or uninsurance. These

studies employ diverse methodologies, but as discussed below, produce estimates which can be rationalized with our findings. We should note, however, that these studies are typically not able to disaggregate the coverage responses by income and state-level public program rules as we do here.

The employment-based coverage responses are reasonable in light of evidence on take-up response found in the literature analyzing previous periods. For adults overall, our estimates imply a coverage elasticity of premium prices between -0.07 and -0.08. For adults between 100% and 300% of FPL, the coverage elasticities range between -0.10 and -

**TABLE A4: REGRESSION ESTIMATES — NATIONAL COVERAGE RESPONSE TO A 10% INCREASE IN PREMIUM COSTS: ALTERNATIVE CATEGORIES OF WORKING FAMILY MEMBER**

<b>Workers</b>	<b>Employer-Based</b>	<b>Public</b>	<b>Private</b>	<b>Uninsured</b>
Under 100% FPL	-0.89%*	0.37%*	-0.11%	0.63%*
100% - 200% FPL	-1.23%*	0.33%*	-0.20%	1.09%*
200% - 300% FPL	-1.01%*	0.23%*	0.07%	0.71%*
300% - 400% FPL	-0.95%*	0.04%	0.08%	0.83%*
Over 400% FPL	-0.34%*	0.00%	0.20%*	0.14%
<b>All</b>	<b>-0.70%*</b>	<b>0.11%*</b>	<b>0.09%</b>	<b>0.50%*</b>
<b>Adult Dependents</b>	<b>Employer-Based</b>	<b>Public</b>	<b>Private</b>	<b>Uninsured</b>
Under 100% FPL	-1.34%*	0.36%*	-0.67%*	1.65%*
100% - 200% FPL	-1.51%*	0.94%*	-0.32%	0.89%*
200% - 300% FPL	-1.10%*	0.38%*	-0.26%	0.98%*
300% - 400% FPL	-0.58%*	-0.04%	0.25%*	0.37%*
Over 400% FPL	-0.46%*	-0.01%	0.19%	0.28%*
<b>All</b>	<b>-0.80%*</b>	<b>0.22%*</b>	<b>0.00%</b>	<b>0.58%*</b>
<b>Children</b>	<b>Employer-Based</b>	<b>Public</b>	<b>Private</b>	<b>Uninsured</b>
Under 100% FPL	-0.01%	0.01%	0.00%	0.00%
100% - 200% FPL	-1.29%*	0.86%*	-0.03%	0.47%*
200% - 300% FPL	-1.07%*	0.70%*	0.07%	0.30%*
300% - 400% FPL	-0.45%*	-0.03%	0.27%*	0.21%*
Over 400% FPL	-0.28%*	-0.01%	0.15%	0.14%
<b>All</b>	<b>-0.60%*</b>	<b>0.29%*</b>	<b>0.09%</b>	<b>0.22%*</b>

0.15. In the existing literature, take-up elasticity is found between -0.04 and -0.09 (Blumberg, Nichols, and Banthin (2002)<sup>2</sup>, Cutler(2002)<sup>3</sup>), and slightly higher (-0.1) for workers under 200% of FPL. (Blumberg, Nichols, and Banthin (2002). Modest eligibility/offer elasticities, coupled with the aforementioned take-up elasticities, can easily rationalize the coverage elasticities documented here.

We can also compare our uninsurance responses to those in the literature. Looking at the 1988-2000 period, Chernew, Cutler and Keenan (2004)<sup>4</sup> find that a \$1000 increase in individual coverage premium (which comes to be around a 60% increase over this period) produces an increase in uninsurance of 2.7 percent points among the non-elderly. Therefore,

a 10% increase in premiums would produce a 0.4 percent point increase in uninsurance in this population. This is slightly greater but close to our estimate of a 0.3 point increase in uninsurance overall for the non-elderly population in response to a 10% increase in premiums (an increase of 0.5, 0.58 and 0.22 points for workers, adult dependents and children, respectively). Finally, using a somewhat different methodology and a longer period of analysis (1979 to 2002), Gilmer and Kronick (2005)<sup>5</sup> predict that the number of uninsured will grow by 11 million between 2003 and 2013, an increase of 1.1 million a year. Our average annual projected increase in uninsurance over 2004 to 2010 (reported below) are slightly higher, but close, at 1.3 million a year for the U.S. population as a whole.

**TABLE A5: REGRESSION ESTIMATES – COVERAGE RESPONSE TO A 10% INCREASE IN PREMIUM COSTS**

<b>All Non-Elderly</b>	<b>Family Income in relation to FPL</b>	<b>Coefficient</b>
Employer-Based	Under 100%	-0.10%
Public	Under 100%	0.07%
Private	Under 100%	-0.05%
Uninsured	Under 100%	0.08%
Employer-Based	100 - 200%	-0.91%*
Public	100 - 200%	0.56%*
Private	100 - 200%	-0.15%
Uninsured	100 - 200%	0.50%*
Employer-Based	200 - 300%	-0.82%*
Public	200 - 300%	0.37%*
Private	200 - 300%	0.03%
Uninsured	200 - 300%	0.42%*
Employer-Based	300 - 400%	-0.61%*
Public	300 - 400%	0.03%
Private	300 - 400%	0.16%*
Uninsured	300 - 400%	0.42%*
Employer-Based	Over 400%	-0.30%*
Public	Over 400%	-0.01%
Private	Over 400%	0.18%*
Uninsured	Over 400%	0.12%*
Employer-Based	Total	-0.49%*
Public	Total	0.17%*
Private	Total	0.05%
Uninsured	Total	0.27%*
<hr/>		
<b>Adults</b>	<b>Family Income in relation to FPL</b>	<b>Coefficient</b>
Employer-Based	Under 100%	-0.14%*
Public	Under 100%	0.10%
Private	Under 100%	-0.07%
Uninsured	Under 100%	0.11%*
Employer-Based	100 - 200%	-0.71%*
Public	100 - 200%	0.40%*
Private	100 - 200%	-0.21%
Uninsured	100 - 200%	0.52%*
Employer-Based	200 - 300%	-0.70%*
Public	200 - 300%	0.21%*

Private 200 - 300%	0.01%	
Uninsured	200 - 300%	0.48%*
Employer-Based	300 - 400%	-0.68%*
Public 300 - 400%	0.06%	
Private 300 - 400%	0.11%	
Uninsured	300 - 400%	0.51%*
Employer-Based	Over 400%	-0.30%*
Public Over 400%	0.00%	
Private Over 400%	0.19%	*
Uninsured	Over 400%	0.12%*
Employer-Based	Total	-0.45%*
Public Total	0.12%	*
Private Total	0.04%	
Uninsured	Total	0.29%*

(\*) Signifies statistical significance at the 5% level

### Future Projections

We simulate future coverage for the United States and for California by taking the 2004 sample of the relevant population (U.S. or California) and applying the relevant price increases to working family members in each scenario. All other variables (family characteristics, job characteristics and “implementation effect” for children’s public coverage) are assumed constant in this simulation. Coverage for non-working families is assumed to remain constant. Therefore, the simulation should be understood as projecting changes in coverage solely due to premium cost increases.

Here we report past (2000 to 2004) and projected (2010) rates for various types of coverage – for all non-elderly individuals, children, and adults in the United States and California.

For the non-elderly population, between 2004 and 2010, employer-based coverage is predicted to fall by about 4 percentage points nationally, and 7 percentage points in California. Uninsurance is predicted to rise by 2 points nationally and 3 points in California. For adults, the corresponding fall in employer-based coverage is predicted to be 4 and 5 points in US and California, respectively.

By 2010, a bare majority (52%) of Californians will have employer-based insurance, somewhat lower than

the national average of 59%. For Californians in the bottom half of the income distribution (under 300% FPL), only 29% will have employer-based coverage, as compared to 37% of all non-elderly individuals in the country.

By disaggregating the projection by five categories of income in table A7 (on page 61), we can see that the sharpest drops in job-based coverage and rise in uninsurance will occur in families with incomes between one and four times the poverty level.

We also predict aggregate coverage numbers that factor in future population growth. We use interim projections from the U.S. Census Bureau for the U.S. non-elderly population, and projections by the California Finance Department for the state-level population. Utilizing the population numbers and our predicted coverage rates, we derive the following projections for the number of individuals in various types of coverage during the 2004-2010 period: adjusted for population growth, if premiums continue to increase 10% each year between 2004 and 2010, job-based coverage will drop from by 3 million nationally, as the number of uninsured will rise by 8 million. 1.5 million fewer adults will have employer-based coverage, and 6.1 million more adults will be uninsured by 2010.

**TABLE A6: PAST AND PROJECTED COVERAGE RATES FOR U.S. AND CALIFORNIA – ALL NON-ELDERLY AND ADULTS BY FAMILY INCOME**

<b>U.S. Non-Elderly</b>	<b>FPL</b>	<b>2000</b>	<b>2001</b>	<b>2002</b>	<b>2003</b>	<b>2004</b>	<b>2010*</b>
Employer-Based	300% and below	47.18%	47.46%	44.93%	43.41%	41.84%	37.02%
Public	300% and below	18.11%	18.39%	20.05%	20.79%	22.28%	25.18%
Private	300% and below	10.25%	11.47%	11.37%	11.26%	10.97%	10.54%
Uninsured	300% and below	26.76%	24.96%	25.97%	26.87%	27.43%	29.78%
Employer-Based	Over 300%	86.43%	86.42%	86.02%	85.20%	84.50%	81.24%
Public	Over 300%	1.43%	1.59%	1.76%	1.90%	1.96%	2.01%
Private	Over 300%	6.00%	6.47%	6.63%	6.77%	7.36%	8.85%
Uninsured	Over 300%	6.90%	6.36%	6.50%	7.03%	7.16%	8.87%
Employer-Based	All	66.68%	67.25%	65.51%	64.20%	62.93%	58.87%
Public	All	9.82%	9.85%	10.89%	11.39%	12.23%	13.75%
Private	All	8.14%	8.93%	8.99%	9.03%	9.19%	9.69%
Uninsured	All	16.90%	15.51%	16.22%	17.00%	17.41%	19.45%
<b>U.S. Adults</b>	<b>FPL</b>	<b>2000</b>	<b>2001</b>	<b>2002</b>	<b>2003</b>	<b>2004</b>	<b>2010*</b>
Employer-Based	300% and below	47.20%	47.62%	45.35%	43.84%	42.37%	38.26%
Public	300% and below	11.85%	11.84%	12.77%	13.07%	13.69%	15.90%
Private	300% and below	11.01%	12.68%	12.62%	12.60%	12.48%	11.85%
Uninsured	300% and below	31.24%	29.23%	30.55%	31.79%	32.88%	35.40%
Employer-Based	Over 300%	86.29%	86.08%	85.71%	84.85%	84.12%	80.71%
Public	Over 300%	0.93%	1.11%	1.16%	1.21%	1.16%	1.29%
Private	Over 300%	5.77%	6.48%	6.58%	6.76%	7.33%	8.79%
Uninsured	Over 300%	7.48%	6.90%	7.13%	7.74%	7.97%	9.79%
Employer-Based	All	67.70%	68.13%	66.58%	65.16%	64.04%	60.28%
Public	All	6.12%	6.12%	6.67%	6.90%	7.18%	8.34%
Private	All	8.26%	9.37%	9.44%	9.56%	9.81%	10.24%
Uninsured	All	18.79%	17.32%	18.23%	19.29%	19.95%	22.12%
U.S. Children	FPL	2000	2001	2002	2003	2004	2010*
Employer-Based	300% and below	47.15%	47.13%	44.04%	42.47%	40.69%	34.39%
Public	300% and below	30.96%	32.12%	35.68%	37.76%	41.01%	45.35%
Private	300% and below	8.70%	8.94%	8.68%	8.30%	7.69%	7.66%
Uninsured	300% and below	17.56%	15.99%	16.11%	16.06%	15.53%	17.53%
Employer-Based	Over 300%	86.83%	87.43%	86.96%	86.26%	85.65%	82.84%
Public	Over 300%	2.93%	3.02%	3.60%	4.01%	4.44%	4.29%
Private	Over 300%	6.67%	6.44%	6.78%	6.83%	7.45%	9.02%
Uninsured	Over 300%	5.15%	4.74%	4.58%	4.87%	4.63%	6.01%
Employer-Based	All	64.17%	65.06%	62.79%	61.75%	60.05%	55.26%
Public	All	18.94%	19.17%	21.66%	22.90%	25.26%	27.67%
Private	All	7.83%	7.83%	7.85%	7.65%	7.59%	8.24%

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Uninsured	All	12.24%	10.98%	11.08%	11.13%	10.84%	12.57%
<b>California Non-elderly</b>	<b>FPL</b>	<b>2000</b>	<b>2001</b>	<b>2002</b>	<b>2003</b>	<b>2004</b>	<b>2010*</b>
Employer-Based	Over 300%	83.21%	83.16%	81.81%	83.14%	81.25%	77.09%
Public	Over 300%	2.10%	1.70%	2.01%	2.45%	2.13%	2.07%
Private	Over 300%	7.42%	8.15%	8.32%	7.86%	9.29%	11.17%
Uninsured	Over 300%	8.69%	7.74%	8.54%	7.60%	8.22%	10.56%
Employer-Based	300% and below	38.24%	38.74%	36.98%	37.36%	34.45%	29.11%
Public	300% and below	21.84%	22.79%	22.68%	22.97%	25.95%	28.71%
Private	300% and below	8.61%	9.98%	10.53%	11.18%	9.97%	9.53%
Uninsured	300% and below	33.76%	30.46%	31.50%	30.88%	31.35%	34.36%
Employer-Based	All	59.19%	59.66%	57.51%	59.06%	56.93%	52.14%
Public	All	12.64%	12.86%	13.22%	13.25%	14.51%	15.95%
Private	All	8.05%	9.12%	9.52%	9.60%	9.64%	10.29%
Uninsured	All	22.08%	19.76%	20.98%	19.85%	20.24%	22.94%
<b>California Adults</b>	<b>FPL</b>	<b>2000</b>	<b>2001</b>	<b>2002</b>	<b>2003</b>	<b>2004</b>	<b>2010*</b>
Employer-Based	Over 300%	83.56%	82.87%	81.71%	82.62%	80.86%	76.36%
Public	Over 300%	1.27%	1.33%	1.34%	1.69%	1.29%	1.28%
Private	Over 300%	7.01%	8.32%	8.09%	8.09%	9.11%	11.06%
Uninsured	Over 300%	8.99%	8.14%	9.31%	8.30%	9.24%	11.80%
Employer-Based	300% and below	38.34%	38.50%	36.99%	37.63%	34.92%	30.04%
Public	300% and below	14.69%	15.10%	14.61%	14.58%	16.05%	17.94%
Private	300% and below	9.63%	11.71%	11.73%	12.44%	12.02%	11.45%
Uninsured	300% and below	38.97%	35.85%	37.78%	36.70%	38.18%	41.74%
Employer-Based	All	60.82%	60.80%	58.87%	60.13%	58.13%	53.43%
Public	All	8.02%	8.18%	8.12%	8.14%	8.60%	9.55%
Private	All	8.33%	10.01%	9.95%	10.27%	10.55%	11.22%
Uninsured	All	24.06%	21.92%	23.85%	22.50%	23.56%	26.63%
<b>California Children</b>	<b>FPL</b>	<b>2000</b>	<b>2001</b>	<b>2002</b>	<b>2003</b>	<b>2004</b>	<b>2010*</b>
Employer-Based	Over 300%	82.16%	84.05%	82.13%	84.67%	82.37%	79.11%
Public	Over 300%	4.56%	2.83%	3.97%	4.68%	4.57%	4.37%
Private	Over 300%	8.63%	7.65%	8.98%	7.19%	9.80%	11.53%
Uninsured	Over 300%	7.81%	6.58%	6.30%	5.54%	5.26%	6.99%
Employer-Based	300% and below	38.05%	39.21%	36.95%	36.81%	33.47%	27.23%
Public	300% and below	35.77%	37.63%	38.06%	40.13%	46.43%	50.89%
Private	300% and below	6.61%	6.64%	8.25%	8.59%	5.72%	5.54%
Uninsured	300% and below	23.62%	20.05%	19.53%	18.98%	17.22%	19.17%
Employer-Based	All	55.34%	56.98%	54.41%	56.48%	54.01%	49.02%
Public	All	23.54%	23.84%	24.88%	25.56%	28.85%	31.35%
Private	All	7.40%	7.04%	8.53%	8.01%	7.43%	8.06%
Uninsured	All	17.42%	14.71%	14.42%	13.45%	12.19%	14.05%



**TABLE A7: CURRENT AND PROJECTED COVERAGE RATES FOR U.S. – ALL NON-ELDERLY AND ADULTS BY DISAGGREGATED FAMILY INCOME**

		All Non-Elderly		Adults		Children	
		2004	2010*	2004	2010*	2004	2010*
Under 100%	Employer-Based	20.25%	19.57%	23.63%	22.65%	12.30%	12.30%
Under 100%	Public	36.50%	37.07%	24.10%	24.91%	65.67%	65.67%
Under 100%	Private	11.14%	10.81%	13.29%	12.83%	6.06%	6.06%
Under 100%	Uninsured	34.05%	34.49%	40.34%	40.97%	19.25%	19.25%
100 - 200%	Employer-Based	41.05%	33.93%	40.77%	34.93%	41.60%	32.09%
100 - 200%	Public	20.78%	25.49%	11.48%	15.28%	39.36%	45.75%
100 - 200%	Private	11.69%	10.62%	13.49%	12.06%	8.09%	7.71%
100 - 200%	Uninsured	29.66%	33.14%	35.81%	39.28%	17.39%	20.89%
200 - 300%	Employer-Based	66.78%	59.78%	65.35%	59.40%	69.97%	60.78%
200 - 300%	Public	8.10%	11.66%	4.25%	6.41%	16.62%	23.12%
200 - 300%	Private	9.99%	10.14%	10.45%	10.51%	8.96%	9.32%
200 - 300%	Uninsured	17.56%	20.84%	21.27%	25.01%	9.33%	11.66%
300 - 400%	Employer-Based	78.68%	73.39%	77.38%	71.49%	82.00%	78.14%
300 - 400%	Public	3.31%	3.64%	1.90%	2.50%	6.89%	6.61%
300 - 400%	Private	8.07%	9.39%	8.28%	9.17%	7.54%	9.88%
300 - 400%	Uninsured	11.19%	14.82%	13.16%	17.57%	6.16%	7.96%
Over 400%	Employer-Based	86.53%	84.00%	86.32%	83.74%	87.21%	84.86%
Over 400%	Public	1.49%	1.44%	0.92%	0.88%	3.39%	3.30%
Over 400%	Private	7.11%	8.66%	7.02%	8.67%	7.41%	8.65%
Over 400%	Uninsured	5.74%	6.77%	6.27%	7.24%	3.97%	5.18%

<sup>1</sup> Center for Medicaid and Medicare Services, 2003 CMS Statistics, U.S. Department of Health Services

<sup>2</sup> Zabin, Carol Arindrajit Dube and Ken Jacobs 2004. "Hidden Public Cost of Low Wage Jobs in California." State of California Labor: Vol. 2004, No. 1.

<sup>3</sup> (Farber and Levy (1998), and author's calculation from March Current Population Survey.)

<sup>4</sup> The Kaiser Family Foundation and Health Research and Educational Trust, Employer Health Benefits 2004 Summary of Findings. Data is from the Kaiser/ HRET Survey of Employer-Sponsored Health Benefits: 1999, 2000, 2001, 2002, 2003, 2004; KPMG Survey of Employer-Sponsored Health Benefits: 1993, 1996; The Health Insurance Association of America (HIAA): 1988, 1989, 1990.

<sup>5</sup> The Kaiser Family Foundation and Health Research and Educational Trust, Employer Health Benefits 2004 Summary of Findings. Data is from the Kaiser/ HRET Survey of Employer-Sponsored Health Benefits: 1999, 2000, 2001, 2002, 2003, 2004; KPMG Survey of Employer-Sponsored Health Benefits: 1993, 1996; The Health Insurance Association of America (HIAA): 1988, 1989, 1990.

<sup>6</sup> Farber, Henry and Helen Levy 1998. "Decline in Employer-Sponsored Health Insurance Coverage: Are Bad Jobs Getting Worse?" NBER Working Paper No. 6709.

<sup>7</sup> Dube, Arindrajit and Alex Lantsberg 2004. "Wage and Health Benefit Restructuring in California's Grocery Industry: Public Costs and Policy Implications." UC Berkeley Center For Labor Research and Education.

<sup>8</sup> Hudman, Julie and Molly O'Malley 2003. "Health Insurance Premiums and Cost-Sharing: Findings from the Research on Low-Income Populations." Kaiser Commission on Medicaid.

<sup>9</sup> Growth rate reflects increase in Medicaid enrollment among children. Centers for Medicare and Medicaid Services

<sup>10</sup> Children accounted for most of the increased take-up in public coverage.

<sup>11</sup> State Fiscal Conditions and Medicaid, Kaiser Commission on Medicaid and the Uninsured April 2004



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