

**Expanding Healthy Families to Cover Parents:
Issues & Analyses Related to Employer Coverage**

**Prepared for the
California HealthCare Foundation**

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ISSUE BRIEF AND READER'S GUIDE

Policy makers in California (and elsewhere) are increasingly interested in expanding health insurance coverage to currently uninsured working parents, as well as to children. Coverage for uninsured parents is important, both for the parents themselves and because covering entire families makes it more likely that children will be covered and receive the care they need. In addition, families will be protected from financial catastrophe (see section I.1).

Many policy makers want to focus new coverage on people who did not previously have it. They do not want new public funds simply to replace or substitute for existing private employer contributions (a phenomenon referred to as “crowd-out”).

Private employment-based coverage is widespread among working families in the Healthy Families income range. Those who become uninsured often regain private coverage in a few months. Therefore, understanding when private employment-based coverage is and is not likely to be available to low-income* parents, and designing policies that reinforce, rather than undermine, job-based coverage for low-income workers, can help target public subsidies.

- Just over 60% of California parents in the 133%-199% FPG[†] income range had employment-based coverage in 1999 (see section II.1 and Table 1)—about twice as many as were uninsured (just under 30%).
- Among *uninsured* parents at this income level, a particularly high proportion (about 45% nationally) had access to employer coverage (see section II.3 and Table 3).

Careful consideration of the relationship between public coverage and employer coverage is even more important in designing a program for parents than for children only. Simply put, the financial incentives for employers with many income-eligible workers to stop offering employment-based coverage are much stronger when public subsidies are available for the entire family.

And low- and modest-wage working parents, realizing that they can get free or relatively inexpensive public coverage for themselves, their spouses and their children, could have strong incentives to seek employment with higher wages and no health benefits or to actively encourage their employer to drop the company health plan and raise workers' wages.

- Average premiums for family coverage through employer plans in California are now about \$6,000 per year, a sizable share of compensation for these workers (see section III.1). Whether the family premium is split 70%-30% (\$4,200/\$1,800) or 50%-50% (\$3,000 each), both employer and worker would benefit greatly if the worker could enroll instead in a state program requiring a much lower contribution.

* As used in this report, the term “low-income” *excludes* “the poor,” i.e., families with incomes below federal poverty guidelines. Income is computed using Healthy Families program rules.

† “FPG” means the federal poverty guidelines, revised annually by the U.S. Department of Health and Human Services.

A public program that potentially offers coverage to a large segment of the state's working population can signal employers to re-think their role in providing health insurance. A firm with many low- and modest-wage workers that does offer health insurance will now be disadvantaged relative to competing firms that enjoy lower costs and can offer higher wages to their workers who obtain coverage through the state program. Many working parents would be income-eligible for public coverage:

- Almost *half* (48.6%) of parents in California have incomes below 250% FPG. More than four in ten (41.2%) have incomes below 200% FPG (see section III.1 and Table 12).

These concerns have played out elsewhere. Recently, “crowd-out” was reported in Rhode Island, where public program coverage was extended to both parents and children well above traditional Medicaid eligibility levels (see section III). That state has recently adopted policies, including premium assistance, to encourage rather than crowd-out employer coverage.

To avoid such coverage shifts, which would likely escalate over time, state policy makers should carefully consider policy options to improve the signals that public coverage of working parents would otherwise send to the private sector. Prudence suggests that serious consideration should be given to a program that includes some combination of sliding-scale contribution requirements, eligibility “firewalls,” and other policies that would encourage rather than undermine employment-based coverage (such as coordinating with employer coverage now available to many uninsured families and encouraging development of new job-based coverage for workers and their families).

One approach for better aligning incentives with private employer coverage would be wage-based contribution requirements for the public program (see section III.3.b).

- Working parents earning between \$30,000 and \$39,999 annually (a wage of about \$15 per hour for a full-time, full-year worker) are almost 12 times more likely to have employer coverage than to be uninsured (see section II.5 and Table 8).

The strong positive correlation between wages and employer coverage suggests taking parents' individual wage levels into account, not just total family income, in setting contribution policies. Using wages to determine required contributions would be more equitable than basing eligibility on a flat-dollar income standard, which does not target uninsured families more effectively than the percent-of-poverty approach (see section II.7).

Another important consideration for the interface between public and private coverage is the duration of uninsured spells parents now experience.

- Nationwide, *half* of all people who lose their health insurance become insured again within less than 6 months (the median duration is 5.3 months). But most “currently uninsured” (those who are uninsured at a point in time) have been uninsured for more than twelve months (see section II.4, Figure 1 and Table 7).

Given that a large number of parents who become uninsured return to private coverage after a brief period, it makes sense to consider eligibility restrictions or “firewalls” to help focus public coverage on those most in need of it and to discourage employers from dropping and workers

from declining existing coverage (see section III.2). Primary firewalls that have apparently helped keep “crowd-out” to a minimum in programs like MinnesotaCare include:

- “Look-back” periods require applicants to have been without employment-based health insurance for some period of time (6 or 12 months) in order to qualify for public coverage.
- Denying eligibility for participation in the public program if employer coverage (that meets certain standards) is available, or was available to the applicant in the recent past.

One way to help uninsured low- and modest-income families make use of employer coverage is to coordinate with existing employer coverage through a “buy-in” program (also called “premium assistance” or “purchasing credits”) (see section III.4.a). An appropriately designed “purchasing credit” initiative for eligible families can encourage use of employer coverage and enable the state to tap into available employer contributions. It can also help to avoid “escalating crowd-out” over time because it would allow eligible families to enroll in employment-based coverage when it becomes available.

Policy makers may desire to further expand work-based coverage as part of a broader strategy to improve the economic situation of low-income working families, as well as to reinforce market expectations for job-based coverage more generally. If so, alternative coverage expansion approaches may be desirable as an adjunct to Healthy Families expansion (see section III.4.b).

A portion of the new coverage funds could be used for pilot or demonstration projects to develop new work-based coverage approaches aimed at businesses that have not traditionally sponsored health insurance coverage—small firms with a majority of low-wage workers.

While in this situation there would be no employer contribution to help reduce public outlays for low-wage families, another potential advantage is that subsidized work-based coverage might substantially improve coverage rates of eligible working families who are reluctant to participate in public programs and would allow them to retain their source of coverage as earnings increase, thus rewarding work and career development. It would also bring into coverage their uninsured higher-wage co-workers at no cost to the state.

Some have expressed concern that such initiatives could strain the state’s administrative capacity while creating an opportunity for employers to shift costs to the state. These concerns can be addressed by developing strategic partnerships, through which the state could parlay the capacity and compatible interest of private and local organizations in California (see section III.4). For example, Blue Cross of California, Pacific Health Advantage and its parent organization, the Pacific Business Group on Health, and the CalOPTIMA program in Orange County have expressed strong interest in developing effective innovations towards this end.

The key goal is to expand public coverage for low-income parents in a way that does not result in public funds going largely to replace existing private employer coverage. While difficult decisions need to be made to avoid or overcome strong economic counter-incentives, innovative policies can be designed to extend public coverage to parents and children who need it while at the same time maintaining or expanding private employment-based coverage.

I. INTRODUCTION

1. Current Policy Context

Policy makers in California (and elsewhere) are increasingly interested in expanding health insurance coverage to currently uninsured working parents, as well as children. Family coverage is attractive for several reasons. Uninsured parents need coverage, of course, but covering parents is also important for children.

Parents are more likely to enroll their children in a health insurance program that they themselves participate in. In some cases, parents may not see the value of enrolling their children in a child-only program while they are healthy; parents can always decide to enroll them later, if and when the children become ill. In other cases, parents may be more likely to participate when it involves a single source of coverage for all family members.

Wisconsin credits inclusion of parents as the reason for its exceptional first-year success in reaching uninsured children under its “BadgerCare” health insurance program. An estimated 95% of Wisconsin uninsured children under 200% of poverty are now covered.¹ As Joe Leean, Secretary of the Wisconsin Department of Health and Family Services observes: Parents are the ones who enroll children in coverage, make premium contributions on their behalf (when required), and take them to the doctor.² So, covering parents in the same program is the best way to reach children.

Children are more likely to get needed care if they are enrolled in the same health plan as their parents. Parents will know better how to get care for their children if they are familiar with how the health plan works because they use it themselves. Available research documents that children are more likely to use care if their parents use care.³

Finally, their parents’ health is important to children’s overall well being. Serious illness, which can be accompanied by loss of earnings and heavy medical expenses, can have ruinous consequences for a family. Health insurance can reduce these risks by removing potential financial barriers to preventive care, encouraging early treatment of medical problems, and covering significant medical expenses.

Federal guidelines released last summer now permit states to apply for demonstration waivers that could allow federal funds available for State Children’s Health Insurance Programs (SCHIP) to be used to cover parents as well as children (within a state’s overall title XXI allotment). Taking advantage of this opportunity, recently enacted legislation (AB 1015) directs California’s Healthy Families Program (HFP) to expand HFP eligibility to uninsured parents of children eligible for Healthy Families, effective July 1, 2001, contingent on receipt of the necessary federal waivers and State appropriations.

As state officials plan for this expansion of public coverage to low-income* working parents (and consider possible strategies to reach other uninsured workers), they do not want new public

* In this paper, we use the term “low-income” to mean children and parents in families in (approximately) the income range served by SCHIP (Healthy Families in California), i.e., families with incomes below the State’s upper limit for SCHIP but above poverty and too high to qualify for Medicaid (except, perhaps, for infants or pregnant

coverage simply to substitute for employment-based coverage previously held by working parents. This is a real concern. As the data presented in this report shows, a majority of low-income (but non-poor) parents (and children) already have employment-based health insurance. Even among uninsured low-income parents, about four in ten were offered coverage by their (or their spouse's) current employer.

Moreover, adding heavily subsidized public coverage for parents makes the relationship with employment-based coverage a substantially more difficult issue than for a children-only program. Given average premiums and contribution requirements for employment-based family coverage, the availability of public coverage to working parents creates much stronger incentives for employers with many low- and modest-wage workers to stop offering employment-based coverage (as compared to when public coverage is available only for children). Even if an employer continues to offer coverage, workers may drop that coverage in order to reclaim their out-of-pocket contribution (or perhaps even to negotiate for higher wages in lieu of health benefits).

For these reasons, state officials need to understand when private employment-based coverage is and is not likely to be available to parents. With this information, policy makers can design efficient and effective coverage for low- and modest-income working parents.

Developing public policies that target subsidies for health coverage efficiently is further complicated by the intersection of two different worlds. Employment-based health coverage is a benefit that many employers offer to attract workers. Thus, its availability and affordability is driven by labor market considerations and tends to vary with wage level, hours worked, and expected duration of employment. On the other hand, eligibility for public programs has come to be based on need, as measured by the ratio of overall family income to the federal poverty guidelines by family size.

2. Purpose and Structure of This Report

These issues demand careful consideration of existing coverage patterns and dynamics, as well as a review of alternative program policy designs. The purpose of this report, therefore, is to identify critical questions related to expansion of public coverage to low-income working parents and to present and analyze available survey data in order to provide policy makers in California with answers to these questions.

California-specific data from the Census Bureau's March 2000 Current Population Survey (CPS), providing data for calendar 1999, are used whenever possible. However, some important issues are not addressed by the March CPS. For these, we use the 1996 Medical Expenditure Panel Survey – Household Component (MEPS-HC), which can produce only national estimates.

The survey data presented in this report is organized as “answers” to the following factual questions.

1. How many low-income parents and children already have employer coverage?

women in the family). There will be some ambiguity as to whether the lower limit is 100% or 133% of the federal poverty guideline (FPG), as minimum federal requirements for Medicaid coverage of children vary by age.

2. How often do parents and children who have access to employment-based coverage decline it?
3. How many uninsured parents and children have current access to employment-based coverage?
4. How long do the uninsured stay uninsured?
5. At what wage level does employment-based coverage become prevalent?
6. How closely do wage level and family income (as a percent of poverty) correlate?
7. How does insurance status by dollar income compare to insurance status by percent of FPG?
8. How much do workers typically pay for employment-based family coverage?

These questions are relevant to an analysis of alternative approaches that might target program expansions to cover those who are most in need, and to discourage both employers and workers from dropping or declining available employer coverage.

The final section of the report discusses key considerations for designing policies to cover uninsured working parents. We emphasize that the policy alternatives mentioned in this paper are based on IHPS' own experience in considering these issues and our knowledge of policies that have been adopted in other states.

3. An Important Note about Family Income and Program Eligibility

Many key questions addressed by this report involve the extent to which employment-based health insurance (EBI) is available to families at varying income levels and, in particular, to families who are likely to be income-eligible for public coverage. Availability of employer coverage is known to rise with income.

Population surveys like CPS and MEPS-HC typically report total income from all sources. However, public programs like Medi-Cal and Healthy Families deduct certain kinds and amounts of income when determining program eligibility. Thus, to report accurately about the extent to which employment-based health insurance is available to families who would be income-eligible for public coverage at alternative income levels, we need to adjust family income reported in the survey data to reflect applicable deductions.

However, the survey data do not contain critical information needed to precisely mimic program eligibility rules, such as childcare costs; and, in any event, detailed modeling of program eligibility is not the purpose of this report. Therefore, we used a “bounding” approach and did all our tabulations twice—once using total income (i.e., without applying any deductions) and again using “net” income (i.e., income after applying the maximum income deductions a family might qualify for under Medi-Cal/Healthy Families).^{*} The body of this report presents only the analysis

^{*} The most important deductions involve work expenses and childcare. California deducts \$90 per month per worker for work expenses (not to exceed actual earnings in a month). California also deducts childcare expenses as paid, up to a maximum of \$175 per month per child (up to \$200 per month for a child under age 2). Neither of the data sources we used included data on actual childcare expenses, so in order to get an “upper limit,” we applied the maximum childcare allowance for every child in the family under age 13, *unless* the family included a parent who never worked during the year. Our data sources did provide months of work during the year and average monthly

based on “net” income. However, the data appendix presents both sets of tables—those based on total income and those based on net income after applicable deductions.^{*4}

Because California has previously expanded Medi-Cal coverage to include parents in families with incomes below 100% FPG, the discussion in the body of this report focuses on parents in families with incomes above poverty but below the upper limit for the Healthy Families Program (250% FPG). Because the eligibility limits for parents are of particular interest, the tables show three categories within this range: 100% to 132% FPG, 133% to 199% FPG and 200% to 249% FPG.

II. DATA

1. How many low-income parents and children already have employer coverage?

In the 133%-199% FPG income range, just over 60% of California parents already had employment-based coverage in 1999, while just under 30% were uninsured (see Table 1). For every low-income uninsured parent, two such parents had employer coverage.

The comparable figures for California children in the 133%-199% FPG income range were 58.7% with employer coverage and 25.3% uninsured—or about 2.3 children with employer coverage for every uninsured child.[†] Children were more than twice as likely as their parents were to receive coverage through public programs—Medi-Cal or Healthy Families.

In comparison, low-income non-parents (adults without children under 19 at home) were less likely to have employment-based coverage (39.4%) and much more likely to be uninsured (45.0%).^{*}

wage, so we were able to estimate the appropriate work-expense deduction for each worker in the family. Thus, our “net income” approach applies the maximum possible deductions a family might qualify for. Viewed in combination, we believe our two approaches—“total income” and “net income”—allow us to present reasonable upper and lower boundaries on employment- and health insurance-related characteristics of low-income families.

^{*} Federal law also makes immigrants who entered the United States legally after August 22, 1996, as well as undocumented aliens, ineligible for many federally supported assistance programs, including Medicaid (Medi-Cal) and SCHIP (Healthy Families). However, our tabulations include *all* survey respondents, regardless of their immigration status.

[†] Differences between parents and children in this income range on these two measures are not statistically significant at the 90% confidence level. The lower rates for non-parents, however, are statistically significant.

Table 1: Percent of Persons with Employment-Based Insurance (EBI) and Percent Uninsured, by Net* Family Income Relative to FPG, California, 1999

% FPG	With Employer Coverage (EBI)			Uninsured			Ratio of EBI to Uninsured**		
	Parents	Children	Non-Parents	Parents	Children	Non-Parents	Parents	Children	Non-Parents
<100%	20.2%	17.5%	21.1%	43.4%	27.5%	49.6%	0.5	0.6	0.4
100% - 132%	42.3%	46.6%	26.5%	37.5%	24.5%	42.9%	1.1	1.9	0.6
133% - 199%	60.5%	58.7%	39.4%	29.9%	25.3%	45.0%	2.0	2.3	0.9
200% - 249%	68.1%	66.9%	50.7%	21.8%	21.2%	31.1%	3.1	3.2	1.6
250% - 399%	84.4%	84.6%	70.5%	7.8%	8.3%	19.0%	10.8	10.2	3.7
400% +	88.0%	89.1%	83.5%	5.3%	7.3%	9.1%	16.6	12.2	9.2
TOTAL	64.5%	56.3%	57.5%	20.6%	18.6%	26.7%	3.1	3.0	2.2

NOTE: Upper and lower (90%) confidence limits for the estimates in Table 1 are shown in Appendix Table C1. The largest such interval is ± 5.2 percentage points. Particularly for parents and children, the difference in rates between contiguous income ranges is often not statistically significant at the 90% confidence level.

* Net family income was calculated by excluding from income amounts or kinds of income not countable under Medi-Cal and Healthy Families program rules. In particular, \$90 per worker per month was deducted for work expenses, as was \$175 per month for childcare expenses for children under age 13 (\$200 per month if the child was under age 2), unless there was a non-working parent in the home.

** The ratio of persons with employer coverage to persons uninsured is presented as an easy way of summarizing the relative prevalence of the two groups by income level. Because it is a ratio of two estimates, each of which is itself subject to sampling variability, this ratio is not a statistically reliable measure.

Source: IHPS analysis of the March 2000 Current Population Survey.

As expected, in the 200%-249% FPG range, more people have employer coverage and fewer are uninsured.* More than two-thirds of parents and children, and slightly more than half of non-parents, have employer coverage. More than three times as many parents and children have employer coverage as are uninsured.

Full details of insurance coverage by income for California parents, children and non-parents are shown in Appendix Tables 1-3. For comparison purposes, the same information is presented for U.S. parents, children and non-parents in Appendix Tables 4-6.

Rates of employer coverage for California parents, children and non-parents by income and by race/ethnicity are shown in Appendix Tables 7-9, and the corresponding rates of uninsurance are shown in Appendix Tables 10-12.

* For non-parents, but not for parents or children, the differences in these rates between the 200%-249% FPG income range and the 133%-199% FPG range are statistically significant at the 90% confidence level. For parents and children, the differences in rates between the 200%-249% FPG income range and the 100%-132% FPG range are statistically significant.

2. How often do parents and children who have access to employment-based coverage decline it?

Some parents and children who are uninsured have been offered health care coverage by their employer but have declined it, presumably because they cannot afford their share of the premium or view other needs as more important.

Table 2 presents national data from December 1996 on the percent of parents, children and non-parents who had access to employment-based insurance in that month, and shows the percent who were enrolled in that insurance.⁵ Also shown are the “take-up rates”—the percent of those with access to coverage who accepted it. Access, coverage, and take-up rates all generally increase with income, although the differences in rates between contiguous income ranges are not always statistically significant.

Table 2: Percent of Persons with Access to Employment-Based Insurance (EBI) and Percent Who Enroll in That Insurance, by Net* Family Income Relative to FPG, United States, December 1996

% FPG	Have Access to EBI			Covered by EBI			“Take-Up” Rate		
	Parents	Children	Non-Parents	Parents	Children	Non-Parents	Parents	Children	Non-Parents
<100%	33.6%	27.4%	20.0%	20.9%	13.1%	13.2%	62.2%	47.9%	66.1%
100% - 132%	70.2%	71.8%	36.6%	52.4%	44.4%	26.8%	74.5%	61.8%	73.2%
133% - 199%	82.7%	85.2%	57.1%	69.3%	62.2%	45.0%	83.8%	73.0%	78.9%
200% - 249%	88.2%	87.9%	69.1%	80.3%	77.7%	55.3%	91.1%	88.4%	79.9%
250% - 399%	90.4%	89.8%	81.0%	84.5%	79.7%	72.8%	93.4%	88.8%	89.9%
400% +	90.2%	89.0%	89.3%	87.1%	84.4%	83.0%	96.5%	94.8%	93.0%
TOTAL	76.6%	69.0%	69.0%	68.2%	55.8%	60.9%	89.0%	80.9%	88.3%

NOTE: Upper and lower (90%) confidence limits for the estimates in Table 2 are shown in Appendix Table C2. The widest limits, in absolute terms, occur in the 100%-132% FPG income range. The difference in rates between contiguous income ranges is not statistically significant at the 90% confidence level for about half of the cells in the table.

* Net family income was calculated by excluding from income amounts or kinds of income not countable under Medi-Cal and Healthy Families program rules. In particular, \$90 per worker per month was deducted for work expenses, as was \$175 per month for childcare expenses for children under age 13 (\$200 per month if the child was under age 2), unless there was a non-working parent in the home.

Source: IHPS analysis of the 1996 Medical Expenditure Panel Survey (full-year panel).

Above 100% FPG, access rates for parents and children are generally similar, but take-up rates (and, therefore, coverage rates) for children are somewhat lower.* Below 400% FPG, access rates are noticeably lower for non-parents (and the differences are statistically significant).

* The difference in take-up rates between parents and children is statistically significant at the 90% confidence level for the <100%, 133%-199% and 250-399% FPG categories.

The association between acceptance (take-up) rates and family income, for both parents and children, suggests that many low-income families with access to employment-based insurance are unable to afford the contribution required to enroll in it. (As discussed in section II.8 below, the amount workers are required to contribute can vary significantly between employers, from nothing to over 40% of the total family premium in some cases.)

The high access rates for parents and children in the 133%-199% FPG and 200%-249% FPG income ranges are particularly noteworthy. More than 80% of parents and children have access to employment-based coverage. In the 133%-199% income range, nearly three in every four children and about five in every six parents accept employer coverage when it is offered. In the 200%-249% FPG income range, access and take-up rates for both parents and children are close to rates in the next higher income range (250%-399% FPG), while access rates for non-parents in that income range are considerably lower.

Full details about access to and take-up of employment-based insurance coverage by income for U.S. parents, children and non-parents in December 1996 are shown in Appendix Tables 13-15.

3. How many uninsured parents and children have current access to employment-based coverage?

A surprisingly high percentage of the uninsured in Healthy Families income ranges have access to employer coverage, even after they have been uninsured for up to a year.

Table 3 presents national data on the percent of parents and children who were uninsured in December 1996 but had access to (i.e., could have enrolled in) employment-based insurance available through a member of their family.⁶ For parents and children, data are shown not only for those without insurance in December (some of whom might have been insured for every month prior to December), but also for those who had been continuously uninsured for several months. In particular, data on access are presented for parents who had been uninsured for at least 1, 3, 6, and 12 months as of December 1996.*

As the table shows, access rates among uninsured U.S. parents and children are highest in the 133%-199% FPG income range.[†] About 45% ($\pm 9\%$) of uninsured parents and almost 70% ($\pm 8\%$) of uninsured children in this income range could have enrolled in employment-based health insurance offered to a family member. Perhaps surprisingly, in this income range, the percent of parents with access to employer coverage does *not* decline significantly when shorter-term uninsured people are excluded from the analysis.

* Because the Healthy Families Program only requires children to have been uninsured for 3 months to qualify, we did not examine access for children who had been uninsured for periods longer than 3 months.

† For parents, the difference in access rates between the 133%-199% FPG category and both the <100% and 400%+ FPG categories is statistically significant at the 90% confidence level, for all durations of uninsurance. The differences in access rates between the 133%-199% FPG category and the other 3 %FPG categories are not statistically significant. For children, the differences in access rates between the 133%-199% FPG category and all other %FPG categories *except* the 100%-132% FPG category *are* statistically significant.

Table 3: U.S. Percent of People Uninsured as of December 1996 Who Have Access* to Employment-Based Insurance, by Net Family Income Relative to FPG and by Length of Time Uninsured**

(Highest access rate in each column is bolded.)

% FPG	Parents				Children	
	Uninsured at least				Uninsured at least	
	1 Month	3 Months	6 Months	12 Months	1 Month	3 Months
<100%	21%	21%	19%	18%	26%	24%
100% - 132%	37%	38%	41%	38%	53%	56%
133% - 199%	46%	45%	46%	45%	69%	68%
200% - 249%	42%	41%	39%	40%	45%	43%
250% - 399%	40%	36%	35%	34%	47%	45%
400% +	25%	20%	13%	15%	31%	18%
TOTAL	31%	30%	30%	29%	41%	39%

NOTE: Upper and lower (90%) confidence limits for the estimates in Table 3 are shown in Appendix Table C3. For parents, the difference in access rates between the 133%-199% FPG category and both the <100% and 400%+ FPG categories is statistically significant at the 90% confidence level, for all durations of uninsurance. The differences in access rates between the 133%-199% FPG category and the other 3 %FPG categories are not statistically significant. For children, the differences in access rates between the 133%-199% FPG category and all other %FPG categories *except* the 100%-132% FPG category *are* statistically significant.

* A person is assumed to have access to employer coverage if any member of the “family insurance unit” (which includes spouses and children under 19 or in college) was offered or is covered by EBI.

** Net family income was calculated by excluding from income amounts or kinds of income not countable under Medi-Cal and Healthy Families program rules. In particular, \$90 per worker per month was deducted for work expenses, as was \$175 per month for childcare expenses for children under age 13 (\$200 per month if the child was under age 2), unless there was a non-working parent in the home.

Source: IHPS analysis of the 1996 Medical Expenditure Panel Survey (full-year panel).

Appendix Table 16 shows that, if the analysis is based on total income (before deductions), similar results are obtained.*

These national data points suggest that a significant number of uninsured low-income parents and children are uninsured because they cannot afford the out-of-paycheck contribution required to enroll in their employer’s plan, particularly for family coverage. At higher income levels, it appears that people generally take the coverage if it is offered, so a lower percentage of those who remain uninsured have access to employer coverage. At lower income levels, coverage is apparently less likely to be available at all.

* In Appendix Table 19, the 200%-249% FPG income range has the highest access rates, which are a few percentage points lower than the highest rates shown in Table 3; but the differences among the 133%-199%, 200%-249% and 250%-399% FPG income categories are not statistically significant.

Because employer-coverage rates are lower in California than nationally for parents (64.5% v. 73.1%), children (56.3% v. 64.0%) and non-parents (57.5% v. 63.3%) at all income levels (compare Appendix Tables 1-3 and 4-6), it is very likely that rates of access to employer coverage are lower in California as well. (As noted, it is not possible to determine from the CPS how many workers could have obtained employer coverage for themselves and their dependents but declined their employer's offer.)

To estimate California-specific access rates for employer coverage, we applied U.S. access rates by race/ethnicity and % FPG categories, from our analysis of the 1996 MEPS, to the estimated distribution of California's population in 1999 by the same categories, from our analysis of the March 2000 CPS.* Although we do not present these highly speculative estimates here, they showed access rates only a few percentage points lower than the national figures. This suggests that significant proportions of uninsured low-income parents and children in California have access to employer coverage but are not enrolled.

We were able to obtain two California-specific pieces of data from the March 2000 CPS that suggest that employer-coverage access rates for uninsured Californians—while lower than national figures—are still significant.

In 1999, most of the approximately 1.53 million California parents whose children were uninsured were uninsured themselves (about five in six) (see Table 4). Of these parents, 15.5% (about 236,000) *did* have employer coverage that could have covered the children as well if the parent chose to enroll for family, rather than worker-only, coverage. (The comparable national percentage was about one-third higher—20.3%.) Although small sample sizes make the figures for low-income (133%-249% FPG) parents less reliable, especially for California, the estimates are similar: Fifteen percent of low-income parents with uninsured children held employer coverage in California, and 20.1% in the nation.

Viewed from the other direction, of the 1.85 million California children who were uninsured in 1999, 14.6% (about 271,000) had parents who had employer coverage. Of these, about 168,000 were in families with incomes below 250% FPG. In this case, California is much closer to the national average: Nationally, 16.2% of uninsured children had a parent covered by employment-based insurance.

* This approach in effect uses race and ethnicity, including Hispanic origin, as a surrogate for a complex variety of factors that produce the observed coverage differences between California and the nation.

Table 4: Insurance Status of Parents Whose Children Are Uninsured: California and United States, 1999

	TOTAL (x1,000)	Parents Uninsured		Parents Have EBI	
		Number (x1,000)	Percent	Number (x1,000)	Percent
California parents	1,529	1,257	82.2%	236	15.5%
U.S. parents	8,295	6,319	76.2%	1,681	20.3%
California children	1,853	1,365	73.7%	271	14.6%
U.S. children	10,804	7,029	65.1%	1,745	16.2%

Source: IHPS analysis of the March 2000 Current Population Survey.

4. How long do the uninsured stay uninsured?⁷

Too often, “the uninsured” are discussed as if they were a static group comprised of the same people, year after year. In fact, while most people have stable health insurance coverage for long periods, others move in and out of coverage frequently. Relatively few of “the uninsured” remain without coverage for years at a time. Only one population survey tracks health insurance coverage of the same people for more than one year. Table 5 presents published data from the Census Bureau’s Survey of Income and Program Participation (SIPP) concerning health insurance coverage over a 36-month period February 1993 through January 1996.

Table 5: Percent Distribution by Months of Health Insurance Coverage Between February 1993 and January 1996, by Age, United States

Number of Months Covered	All Ages	< 18	18-24	25-34	35-44	45-65	65 +
No Months (Always Uninsured)	3.7%	3.2%	4.9%	5.2%	4.7%	3.7%	0.0%
1-24 Months (Uninsured 12-35 Months)	12.1%	13.1%	25.2%	15.5%	10.7%	8.9%	0.1%
25-30 Months (Uninsured 6-11 Months)	4.6%	5.6%	9.8%	5.5%	3.9%	2.8%	0.1%
31-35 Months (Uninsured 1-5 Months)	8.6%	10.6%	15.3%	9.9%	7.2%	6.7%	0.2%
36 Months (Never Uninsured)	71.0%	67.5%	44.8%	63.9%	73.6%	77.9%	99.6%
TOTAL	246,156	68,894	23,807	41,423	39,576	47,023	25,432

Source: Robert L. Bennefield, “Who Loses Coverage and for How Long?” Dynamics of Economic Well-Being: Health Insurance, 1993 to 1995. Current Population Report P70-64. U.S. Census Bureau, August 1998. Table 5. (Detailed table not in published report accessed from <http://www.census.gov/hhes/hlthins/hlth9394.html>, December 12, 2000.)

As can be seen, only a very small portion of the population—3.7%—was continuously uninsured over this entire three-year period. Another one-quarter of the entire population (and larger percentages in the younger age groups) was without coverage for between one month and 35 months. The “continuously uninsured” represent only 12.8% of the people who were uninsured at any time during the period—about one in eight. Those who were uninsured for a year or more represent 54.5% of those who were uninsured at any time during the period. Table 6 presents similar information for people at different income levels relative to federal poverty thresholds.

Table 6: Percent Distribution by Months of Health Insurance Coverage Between February 1993 and January 1996, by Income-to-Poverty Ratios,* United States

Number of Months Covered	All Incomes	< 1.0	1.0 to 1.49	1.5 to 1.99	2.0 to 2.99	3.0 to 3.99	4.0 to 4.99	5.0 to 5.99	6.0 +
No Months (Always Uninsured)	3.7%	9.3%	10.1%	6.4%	2.8%	1.6%	0.9%	0.5%	0.3%
1-24 Months (Uninsured 12-35 Months)	12.1%	22.3%	28.0%	21.2%	12.6%	6.7%	3.7%	3.1%	2.3%
25-30 Months (Uninsured 6-11 Months)	4.6%	7.5%	8.3%	6.7%	4.8%	3.9%	2.6%	1.8%	1.5%
31-35 Months (Uninsured 1-5 Months)	8.6%	10.5%	9.6%	9.3%	9.5%	8.5%	7.9%	6.6%	5.5%
36 Months (Never Uninsured)	71.0%	50.4%	44.1%	56.4%	70.3%	79.3%	84.9%	87.8%	90.4%
TOTAL	246,156	27,471	23,547	26,490	51,178	41,883	28,149	17,052	30,386

* This table uses poverty thresholds as defined by the Census Bureau, which are not the same as the federal poverty guidelines issued by the Department of Health and Human Services for program purposes. All other tables in this report are based on the federal poverty guidelines (FPG).

Source: Robert L. Bennefield, “Who Loses Coverage and for How Long?” Dynamics of Economic Well-Being: Health Insurance, 1993 to 1995. Current Population Report P70-64. U.S. Census Bureau, August 1998. Table 8. (Detailed table not in published report accessed from <http://www.census.gov/hhes/hlthins/hlth9394.html>, December 12, 2000.) See also Figure 3 in published report.

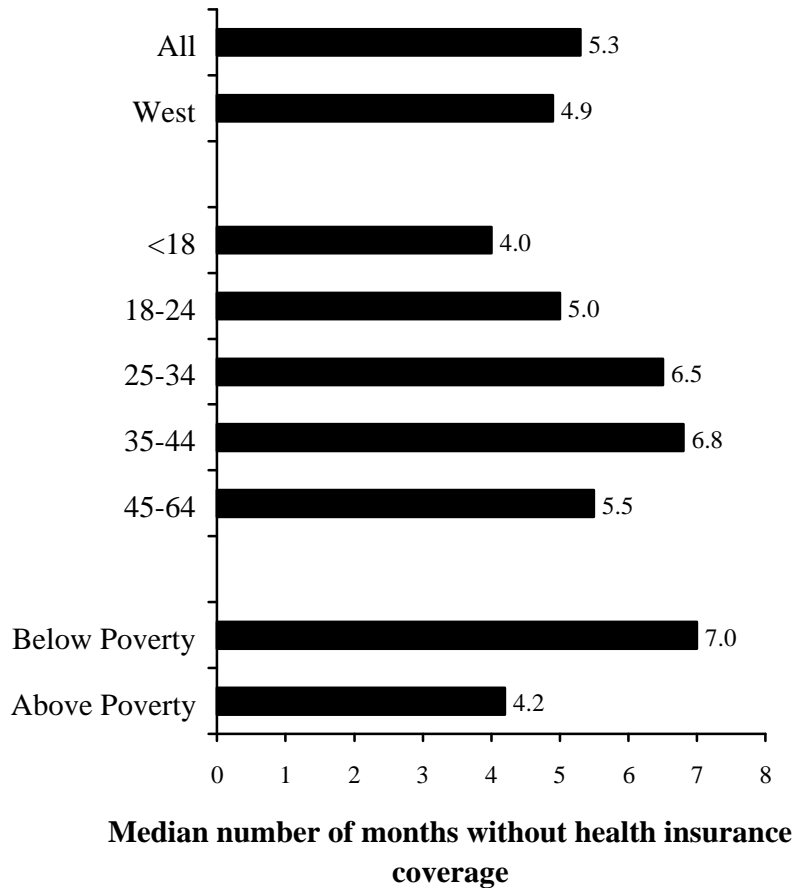
As Table 6 shows, people with incomes between 100% and 149% of the poverty level are most likely to have been uninsured throughout the 36-month period—10.1% were without coverage for the entire period, compared to 3.7% of all people regardless of income. They were also least likely (of any income group) to have been insured throughout the entire 36-month period—only 44.1% were always insured, compared to 71.0% of all income groups. It is important to note, however, that a relatively high proportion of the population had coverage for at least some portion of the 36-month period, even for those with incomes below 300% of the poverty level.

Another way of looking at this same phenomenon is to ask how long a typical “spell of uninsurance” lasts. A published analysis of the 1993 SIPP panel^{*} shows that the median number

* I.e., households whose first SIPP interview was in 1993. They were reinterviewed several times over the subsequent 36 months.

of months without health insurance coverage was 5.3 nationally (4.9 in the West).⁸ That is, of all people who lost health insurance coverage at any time between February 1993 and January 1996, half of them remained uninsured for less than 5.3 months, and half for 5.3 months or longer. The median time without insurance was even briefer for children under 18 (4 months) and was longer for adults aged 25-34 (6.5 months) and 35-44 (6.8 months), but the published SIPP data do not report separately for adults who are and are not parents (see Figure 1).

Figure 1: Duration of Spells Without Health Insurance Coverage (by Age and Poverty Status): 1993 to 1996



Source: Robert L. Bennefield, "Who Loses Coverage and for How Long?" Dynamics of Economic Well-Being: Health Insurance, 1993 to 1995. Current Population Report P70-64. U.S. Census Bureau, August 1998. Figure 4.

Thus, we observe that "the uninsured" (i.e., the population that loses health insurance at least once over a 36-month period) may be divided into two groups. One group, relatively small, remains uninsured for long periods. The other group, considerably larger, loses health insurance from time to time, but most often for periods of less than six months. (Presumably, these periods of uninsurance are related to job loss or change.) These two groups have different needs over time, and therefore present different policy issues.

When most people refer to “the uninsured,” it seems they are thinking about those who do not have coverage at the present time. Based on the Medical Expenditure Panel Survey, Table 7 shows the national percent distribution of parents who were uninsured at a particular point in time (the month of December 1996) by the number of months they had been without employer coverage during 1996 and by family income as % FPG. It is important to note that this view of “the uninsured” may be misleading with respect to the number of short-term uninsured. By definition, it excludes those who were uninsured for short periods earlier in the year but who had regained coverage by the study month. (The policy relevance of the number of short-term uninsured is discussed below in section III.2.a.)

Table 7: U.S. Parents Uninsured in December 1996: Percent Distribution by Length of Time Without Employment-Based Insurance (EBI), by Net Family Income* Relative to FPG

% of FPG	Total	1-3 months	4-6 months	7-11 months	12 months	7 months or more
<100%	100.0%	3.3% (± 1.5%)	4.4% (± 2.4%)	3.3% (± 1.7%)	89.0% (± 3.1%)	92.3%
100%-133%	100.0%	4.4% (± 5.3%)	6.8% (± 4.0%)	3.0% (± 2.6%)	85.8% (± 6.7%)	88.9%
133%-199%	100.0%	9.6% (± 4.6%)	7.3% (± 4.7%)	6.9% (± 4.6%)	76.2% (± 7.2%)	83.1%
200%-249%	100.0%	10.0% (± 6.9%)	8.5% (± 5.4%)	4.7% (± 6.0%)	76.8% (± 9.8%)	81.5%
250%-399%	100.0%	19.9% (± 10.0%)	16.4% (± 8.8%)	4.3% (± 2.4%)	59.5% (± 10.8%)	63.7%
400%+	100.0%	25.3% (± 10.5%)	12.8% (± 7.4%)	7.3% (± 8.2%)	54.7% (± 11.8%)	61.9%
TOTAL	100.0%	9.1% (± 2.0%)	7.8% (± 2.1%)	4.5% (± 1.5%)	78.6% (± 2.9%)	83.1%

NOTE: Figures in parentheses indicate 90% confidence intervals for these estimates. Numerical values of the upper and lower confidence limits for the estimates in Table 7 are shown in Appendix Table C7.

* Net family income was calculated by excluding from income amounts or kinds of income not countable under Medi-Cal and Healthy Families program rules. In particular, \$90 per worker per month was deducted for work expenses, as was \$175 per month for childcare expenses for children under age 13 (\$200 per month if the child was under age 2), unless there was a non-working parent in the home.

Source: IHPS analysis of the 1996 Medical Expenditure Panel Survey (full-year panel).

Below 250% FPG, more than three in four parents who are uninsured in a given month have been without employment-based insurance (EBI) for a full year. Even above 250% FPG, a majority have been without EBI for a year.*

A larger proportion of children than parents was uninsured for all 12 months of 1996,† probably as a result of higher employer contributions for worker-only coverage than for family coverage

* Many of these have probably been without insurance for more than one year, but the MEPS full-year file does not have information on coverage status prior to January 1996.

† Across all income ranges, the difference between parents and children in the proportion of the uninsured who were uninsured all year (78.6% v. 82.2%) is statistically significant at the 90% confidence level. In individual % FPG categories, the point estimate for children is usually higher than the point estimate for parents, but the differences are not statistically significant.

(see Appendix Tables 17 and 18; Appendix Table 19 shows this same information for non-parents).

Among low-income families (133%-199% FPG and 200%-249% FPG), more than three in four parents and children who are uninsured in any given month have been without employment-based health insurance for 12 or more months. Given the generally lower employer coverage percentages in California compared to the United States as a whole, these percentages are likely to be even higher for California.

Again, unlike the SIPP analysis presented earlier, Table 7 does *not* include parents who were uninsured for some portion of 1996 but had become insured again prior to December of that year. It omits many relatively short “spells of uninsurance” that parents experienced during 1996. Single-year data from SIPP for 1994 indicates that the number of people who were uninsured for part of that year was 1.8 times the number of people who were uninsured for the entire year.⁹

5. At what wage level does employment-based coverage become prevalent?

Employment-based health coverage is a benefit employers offer to compete for labor. Thus, its availability and affordability are driven by labor market considerations and tend to vary with wage level (as well as hours worked and expected duration of employment). Businesses are less likely to offer coverage if their employees earn low wages (and are also less likely to do so if they are small firms, employing fewer than 50 workers).¹⁰ Eligibility for public programs, on the other hand, has generally been based on need as measured by the ratio of overall family income to the federal poverty guidelines by family size.

This divergence of constructs means that families with the same income, especially when measured as a percent of poverty, may be in very different work situations with respect to availability (and cost) of employment-based health coverage. For example, a single parent with one child has a total family income equal to 175% of the federal poverty guideline if the parent works full-time and earns \$9.46 per hour. A single full-time worker with a non-working spouse and two children can earn 50% more—\$14.34 per hour—and still be at the same 175% of poverty. But the employment and benefits environments at those two jobs are likely to be very different.

When government seeks to design policies to expand health coverage of low-income families without replacing employment-based coverage already available to many of those families, it is important to understand how work-related variables such as wage rates may influence what policies and program approaches best meet public policy goals.

Table 8 displays the distribution by insurance status and wage level (earnings at longest job) of California parents in 1999.

The discussion in this section focuses on the relationship between workers’ earnings and the likelihood they will be offered coverage by their employer (and therefore the column showing employer coverage in own name is highlighted in Table 8).

Table 8: Parents (of Children under 19) in California by Earnings at Longest Job, 1999: Total (in thousands) and Percent Distribution by Insurance Status

(Bolding highlights data discussed in the text.)

Earnings*	Total (x1,000)	Employer Coverage (EBI)			Medi-Cal	Other	Uninsured	Ratio: EBI (Own) / Unins
		Total	Own Name	Depen- dent				
Less than \$15,000	1,790	44.6%	20.5%	24.1%	16.9%	4.9%	33.7%	0.61
\$15,000 to \$19,999	704	59.2%	46.6%	12.6%	7.0%	3.9%	29.8%	1.56
\$20,000 to \$29,999	1,003	81.3%	61.9%	19.4%	1.1%	3.3%	14.3%	4.34
\$30,000 to \$39,999	726	88.9%	75.6%	13.3%	0.9%	2.6%	7.6%	9.94
\$40,000 or more	1,821	91.8%	79.6%	12.3%	0.1%	3.6%	4.4%	17.89
All Wage & Salary Workers	6,044	71.9%	54.8%	17.1%	6.2%	3.8%	18.1%	3.04
Self-Employed and Non-Workers	2,333	45.2%	9.6%	35.6%	14.8%	12.8%	27.2%	0.35
TOTAL	8,377	64.5%	42.2%	22.3%	8.6%	6.3%	20.6%	2.05

NOTE: Upper and lower (90%) confidence limits for the estimates in Table 8 are shown in Appendix Table C8. Statistical uncertainty is particularly large for the estimates of "Medi-Cal" and "Other."

* Wages earned at job held for the longest time during 1999, excluding self-employment. Includes part-time and part-year employment.

Source: IHPS analysis of the March 2000 Current Population Survey

The strong positive association between wage level and coverage through one's own employer is clearly evident from the table.* The rate of own-employer coverage exceeds the average for all wage and salary workers once earnings exceed \$19,999 (about \$10 per hour). Above \$30,000 in annual earnings (a wage of about \$15 per hour for a full-time, full-year worker), coverage through the parent's own employer coverage becomes prevalent, and the uninsured rate is low. Working parents earning \$30,000 to \$39,999 annually are ten times more likely to have coverage through their own employer than to be uninsured. It appears that wage level is a very good proxy for availability of employer coverage.

This finding is consistent with previously published national analyses, which showed that almost all workers earning more than \$15 per hour in early 1996 (93.4%) were offered coverage by their own employer, and 85.7% of those offered accepted the coverage.¹¹ That is, about 80% of these workers had coverage through their own employer.

The strong positive correlation between wages and employer coverage suggests that taking parents' wage levels into account, not just total family income, could be a powerful tool in

* The differences in rates of own-employer coverage between earnings categories are statistically significant at the 90% confidence level *except* between the \$30,000-\$39,999 and \$40,000 or more categories.

designing policies to expand coverage of the uninsured rather than simply substituting public for existing employment-based coverage.

6. How closely do wage level and family income (as a percent of poverty) correlate?

Or, phrased more concretely, how often do higher-wage workers live in lower-income families (relative to the poverty guidelines), or low-wage workers in higher-income families?*

Since higher-wage working parents are very likely to have (or at least have access to) employer-based coverage, one question relevant to the risk of crowd-out is how often such likely-to-have-access workers live in families whose income is low enough to qualify them for public coverage.

Table 9 shows the percent distribution of working parents by wage level (annual earnings at longest job held during the year) within % FPG categories for family income. In order to assure, as much as possible, that the annual earnings shown reflect actual salary rates or hourly wage levels, the table is limited to full-time, full-year workers.† Also, self-employed workers are excluded from the earnings categories. For easier interpretation, the <100% and 100%-132% FPG categories have been collapsed.

As we learned in the previous section, employer coverage becomes prevalent once an individual's earnings level exceeds \$30,000 per year. Above \$40,000 per year, very few working parents lack health insurance coverage.

Table 9 shows that 13.1% of full-time full-year (FTFY) working (non-self-employed) parents in the 200%-249% FPG income range earn more than \$40,000 annually, and another 34.3% earn between \$30,000 and \$39,999 per year. In the 133%-199% FPG income range, about 3.1% of FTFY non-self-employed working parents earn more than \$40,000 annually, while 16.3% earn between \$30,000 and \$39,999. Analysis of this data by marital status (not shown) confirms that all but a few of these higher-earning parents in "lower income" families are married. Appendix Table 20, in the same form as above, presents the distribution within % FPG categories using total family income without any deductions. Potential policy implications of this observation are discussed later.

* Because the federal poverty guidelines take into account family size, a high-paid worker could be in a relatively low % FPG category if he or she had several children and was the only earner in the family. Conversely, a low-paid worker could be in a relatively high % FPG category if his or her spouse was more highly paid, or if the family had significant income other than earnings from work.

† Because CPS reports earnings data for an entire year, including part-year or part-time workers would make it appear that more workers had low wage *rates* than is actually the case.

Table 9: Poverty Status of Working Parents (of Children under 19) by Annual Earnings at Longest Job, California, 1999: Percent Distribution Within % FPG Categories

(Bolding highlights data discussed in the text.)

Annual Earnings*	Total (x1,000)	Net Family Income** Relative to FPG				
		<133%	133%-199%	200%-249%	250%-399%	400%+
Less than \$15,000	581	51.2% (± 7.5%)	19.6% (± 7.2%)	5.5% (± 5.1%)	4.0% (± 2.7%)	2.1% (± 1.5%)
\$15,000 to \$19,999	481	32.6% (± 7.1%)	19.2% (± 7.2%)	11.5% (± 7.2%)	7.6% (± 3.7%)	1.6% (± 1.3%)
\$20,000 to \$29,999	785	15.7% (± 5.5%)	41.9% (± 9.0%)	35.5% (± 10.8%)	19.6% (± 5.5%)	9.1% (± 2.9%)
\$30,000 to \$39,999	647	0.5% (± 1.1%)	16.3% (± 6.7%)	34.3% (± 10.7%)	24.3% (± 6.0%)	13.5% (± 3.5%)
\$40,000 or more	1,684	0.0%	3.1% (± 3.1%)	13.1% (± 7.6%)	44.4% (± 6.9%)	73.7% (± 4.5%)
All Wage & Salary Workers [=100%]	4,177	759	522	339	892	1,665

NOTE: Figures in parentheses indicate 90% confidence intervals for these estimates. Numerical values of the upper and lower confidence limits for the estimates in Table 9 are shown in Appendix Table C9.

* Wages earned at job held for the longest time during 1999, excluding self-employment. Includes full-time, full-year workers only.

** Net family income was calculated by excluding from income amounts or kinds of income not countable under Medi-Cal and Healthy Families program rules. In particular, \$90 per worker per month was deducted for work expenses, as was \$175 per month for childcare expenses for children under age 13 (\$200 per month if the child was under age 2), unless there was a non-working parent in the home.

Source: IHPS analysis of the March 2000 Current Population Survey.

Another aspect of the wage-versus-income question is how often low-wage workers live in higher-income families. This question is relevant primarily for proposals (discussed later) that would subsidize coverage provided through small, low-wage firms and/or to low-wage workers (i.e., where family income would not be assessed and the subsidy would be paid through the employer).

Table 10 shows the percent distribution of working parents by family income relative to poverty within wage level (earnings) categories (defined as above). Appendix Table 21, in the same form, presents the distribution by % FPG using total family income without any deductions.

About one in eight California parents (12.3%) who worked full-time for all of 1999 and earned less than \$15,000 (about \$7.50 per hour) live in families with incomes that exceed 250% FPG (net of maximum available program deductions). Relatively few (3.2%) of these lowest-wage working parents live in families with income between 200% and 249% FPG. About one in five California parents (19.5%) who earned between \$15,000 and \$19,999 in that year also have family incomes that exceed 250% FPG.

Table 10: Poverty Status of Working Parents (of Children under 19) by Net Family Income Relative to FPG, California, 1999: Percent Distribution by Annual Earnings at Longest Job Held**

(Bolding highlights data discussed in the text.)

Annual Earnings*	Total (x1,000) [=100%]	Net Family Income** Relative to FPG				
		<133%	133%-199%	200%-249%	250%-399%	400%+
Less than \$15,000	581	66.9% (± 8.1%)	17.6% (± 6.6%)	3.2% (± 3.0%)	6.1% (± 4.1%)	6.2% (± 4.1%)
\$15,000 to \$19,999	481	51.5% (± 9.5%)	20.8% (± 7.7%)	8.1% (± 5.2%)	14.1% (± 6.6%)	5.4% (± 4.3%)
\$20,000 to \$29,999	785	15.2% (± 5.3%)	27.8% (± 6.6%)	15.3% (± 5.3%)	22.3% (± 6.2%)	19.3% (± 5.9%)
\$30,000 to \$39,999	647	0.6% (± 1.3%)	13.2% (± 5.5%)	18.0% (± 6.3%)	33.5% (± 7.7%)	34.7% (± 7.8%)
\$40,000 or more	1,684	0.0%	0.9% (± 1.0%)	2.7% (± 1.6%)	23.6% (± 4.3%)	72.9% (± 4.5%)
All Wage & Salary Workers	4,177	18.2% (± 2.3%)	12.5% (± 2.0%)	8.1% (± 1.6%)	21.4% (± 2.5%)	39.9% (± 3.0%)

NOTE: Figures in parentheses indicate 90% confidence intervals for these estimates. Numerical values for the upper and lower confidence limits for the estimates in Table 10 are shown in Appendix Table C10.

* Wages earned at job held for the longest time during 1999, excluding self-employment. Includes full-time, full-year workers only.

** Net family income was calculated by excluding from income amounts or kinds of income not countable under Medi-Cal and Healthy Families program rules. In particular, \$90 per worker per month was deducted for work expenses, as was \$175 per month for childcare expenses for children under age 13 (\$200 per month if the child was under age 2), unless there was a non-working parent in the home.

Source: IHPS analysis of the March 2000 Current Population Survey.

7. How does insurance status by dollar income compare to insurance status by percent of FPG?

Public program eligibility standards are traditionally based on the federal poverty guidelines, which vary by family size. A flat-dollar eligibility standard for family income, while less equitable, might be more consistent with the availability of employment-based insurance, which tends to vary with workers' wage levels, ignoring family size. However, comparison of the two approaches suggests that the percent-of-poverty approach remains superior.

Table 11 shows that, in 1998, a flat-dollar standard of \$45,000 would have made only a few more uninsured parents eligible than a 250%-FPG standard would have (85.8% under \$45,000, 83.5% under 250% FPG).^{*} Rates for both employer coverage and uninsurance (not shown) were similar for parents with incomes above these levels, but the flat-dollar approach would have captured a larger proportion of all parents (52.0% v. 47.9%) and of parents who already had

^{*} This analyses was done before the March 2000 Current Population Survey (CPS) became available. It is based on the March 1999 CPS and thus reflects family income in 1998. Also, because this table was produced at an earlier stage of the analysis, it was based on total or gross family income. Deductions allowable under Medi-Cal and Healthy Families program rules were *not* applied.

employer coverage (34.1% v. 28.7%). Thus, the flat-dollar approach (at least at the \$45,000 level) would heighten the risk of crowd-out.

Fewer large families would be eligible for public coverage under a flat-dollar standard, but their salary levels make it very likely they would have access to employer coverage. Conversely, more small families would be eligible; and, because these families could have higher incomes (and earnings) than before, they would be more likely to have access to employer coverage. Thus, we conclude that the flat-dollar approach does not target uninsured families more effectively than the percent-of-poverty approach.

Table 11: Distribution of Parents (of Children under 19) by Two Measures of Gross Family Income Within Insurance Status Categories: California, 1998

Family Income in Dollars	Total Population	Employer Coverage	Uninsured	Family Income as %FPG	Total Population	Employer Coverage	Uninsured
Less than \$30,000	36.3%	17.3%	69.8%	<133%	25.3%	9.8%	49.9%
\$30,000 to \$44,999	15.7%	16.9%	16.0%	133% - 249%	22.6%	18.9%	33.7%
\$45,000 or more	48.0%	65.9%	14.2%	250% +	52.1%	71.3%	16.5%
TOTAL	100.0%	100.0%	100.0%	TOTAL	100.0%	100.0%	100.0%

* Estimate too small to be reliable.

Source: IHPS analysis of the March 1999 Current Population Survey.

Another disadvantage of using a flat-dollar income standard is that doing so would make it easier for employers to assess how many of their workers might qualify for public coverage, which could lead more employers to decide to drop coverage.

8. How much do workers typically pay for employment-based family coverage?

To understand the extent to which working parents who currently have employment-based coverage might be tempted to drop that coverage in order to qualify for a new public program, it is useful to know how much workers typically have to pay to obtain family coverage through their employer.

One policy alternative designed to discourage workers from dropping employer coverage, for example, would be to charge a premium for enrollment. At the upper end of the eligible income range, or at higher wage levels, such a premium might reflect the full cost of providing coverage through the public program, or it might reflect what a typical employer charges their workers for family coverage. To assure affordability, premiums would vary with income or wages.

Available data from employer surveys suggest that workers in California who actually enrolled in full family coverage paid an average of around \$110-\$115 per month for that coverage in 1998-1999, or about one-quarter of the total premium.^{12,13}

A focus on averages, however, masks the fact that contribution requirements vary considerably across employers. An unpublished analyses of the 1999 California Employer Survey found that

about one in six California employers (16.4%) pay the full cost of family coverage, while about one in five (19.9%) pay less than 60% of the cost.¹⁴

An analysis of the 1997 Robert Wood Johnson Foundation Employer Survey by RAND economists Steve Long and Susan Marquis found that, nationally, 29% of enrolled workers received an employer contribution of less than 60% toward the cost of family coverage, while 31% received a contribution of between 60-79% of the total cost. Among workers at small firms, 44% received an employer contribution of less than 60% of the cost of family coverage, but small-firm workers were also the most likely (45%) to receive a contribution of 80% or more toward family coverage.¹⁵

Both employer size and general wage level of an employer's work force affect how much an employer pays toward workers' health coverage. Employers with many low-wage workers tend to contribute less, as do smaller employers.¹⁶

It is important to note that all of these contribution estimates are based on workers who are *actually enrolled in family coverage*. These workers are likely to have higher incomes and face lower contribution requirements than workers who declined family coverage.¹⁷ And employer contribution levels do matter. Long and Marquis found that, where the employer paid less than 60% of the cost of family coverage, 42% of enrollees elected family coverage (38% in small firms, 43% in larger firms). Where the employer paid 80% or more, five in nine enrollees (55%) elected family coverage (51% in small firms, 57% in larger firms).¹⁸ In unpublished work, Long and Marquis also found that workers in low-wage establishments faced lower employer contributions than workers in other firms.

III. KEY CONSIDERATIONS FOR POLICY DESIGN

As noted in the introduction, it is important to expand health insurance coverage for currently uninsured working parents, both for the parents themselves and because covering entire families ensures that more children will be covered and receive the care they need. But, in designing programs that will use public funds to cover uninsured workers, through whatever mechanism, policy makers generally want to use funds as efficiently as possible. They want new public funds to buy coverage for people who did not have it before; and they do not want new public funds simply to replace or substitute for private employer contributions that were already being spent on health insurance (a phenomenon referred to as “crowd-out”).

As the data presented in this report has shown, it is a difficult task to target public subsidies efficiently because private employment-based coverage is already widespread among low-income working families. These families are the primary intended beneficiaries of expanded public support for health insurance coverage, and, as shown, their health insurance status changes frequently.

Most importantly, there is good reason to believe that the availability of public coverage to working parents will create strong incentives for employers with many modest-wage workers to stop offering employment-based coverage—much stronger incentives than when public coverage is available only for children. This phenomenon has apparently occurred in Rhode Island, where the “RIteCare” program, a Medicaid demonstration project, provides free coverage to parents and children well above traditional Medicaid eligibility levels. The *Providence Journal* reported in May 2000 that as many as 20,000 people—almost 20% of total program enrollment—may have dropped private health insurance in order to take advantage of the free state program. The largest participating HMO, Neighborhood Health Plan, estimated that one-third of its new RIteCare patients were migrating from private insurance plans.¹⁹ As a result of these coverage shifts, Rhode Island initiated a premium assistance program to assist families in accessing employer coverage.

These reports indicate a substantial risk. Over time, a broad public program for modest-income working families, if not properly designed, could lead to a massive shift of parents and children out of current employment-based coverage and into the new public program, at great cost to the state with potentially little reduction—and perhaps even an increase—in the number of uninsured.

While trade-offs must be made, we believe that it is possible to design program policies that will extend health insurance coverage to those who need it while simultaneously maintaining, and perhaps expanding, employment-based coverage for those who have access to it.

Continuation of work-based health insurance is appealing for more than fiscal reasons. A number of policy makers believe that work-based coverage is an important part of a broader strategy to improve the economic situation of low-income working families. With public funds available to subsidize coverage for parents as well as children, better opportunities to develop effective premium-assistance approaches for work-based coverage of uninsured working families may be created.

The desire to cover all members of the family through the same health plan and to provide a stable source of coverage also suggest that it is important for policy makers to consider when it makes sense to enroll the entire family in public coverage and when it may make more sense instead to encourage the family's enrollment in employment-based coverage if it is available.

The simple truth, however, is that the number of uninsured Californians cannot be reduced without significant public subsidies. Furthermore, by extending coverage to uninsured low- and modest-income parents, it may be possible to reach uninsured children who are eligible for, but have not yet enrolled in, Medi-Cal or Healthy Families.

Therefore, in this section, we offer policy options aimed at achieving these multiple public policy objectives. First, we explain why we believe the risk of "crowd-out" is much greater when public coverage becomes available to parents as well as children.

1. Why covering parents creates stronger incentives for "crowd-out" than covering children only.

Most employers view health care coverage as a benefit for workers. While they contribute toward coverage of dependents, they typically contribute a higher percentage of premium for coverage of the worker.*

If public coverage is available for low-income children, a few employers may realize that they could reduce their contribution towards children's coverage and save money (or increase workers' basic wages). These employers would include those that now have mostly low-wage workers, yet offer health insurance and contribute significantly toward coverage of children. They would still offer a health insurance plan and would still have to contribute a significant amount for worker-only coverage (and for workers' spouses, if the employer is so inclined).

If low- and modest-income parents are eligible for public coverage, as well as their children, the incentives for employers change considerably. While firms with relatively few low- and modest-wage workers seem unlikely to change their health insurance plans in response to expanded public coverage, firms with numerous modest- to median-wage workers will have strong incentives to do so, simply because health insurance is expensive. Average premiums for family coverage through employer plans in California are now about \$6,000 per year.²⁰ Even those low-wage employers that do now offer coverage pay an average of about 70% of total premium (nationally), or about \$4,200.²¹ If employers' low-wage workers earn as much as \$10 per hour on average (about \$20,000 per year), that typical employer contribution represents more than 20% of salary costs—a very significant proportion. Whether the family premium is split 70%-30% (\$4,200/\$1,800) or 50%-50% (\$3,000 each), both employers and workers would benefit greatly if workers could enroll instead in a state program requiring a much lower contribution.

* Fully insured employers must meet their carriers' group-participation requirements among eligible workers in order to maintain coverage. Because of potential risk selection, participation requirements tend to be more stringent for small employers. Thus, if they offer coverage at all, small, low-wage employers in particular usually have to contribute a very high proportion of premium for basic worker-only coverage in order to assure that enough of their workers enroll, at least for single coverage.

If subsidized coverage were available to employees who have children, terminating health insurance coverage entirely would be a realistic option for many employers with mostly low- and modest-wage workers, because their other, childless workers, usually younger, typically do not value health insurance as much as parents do.* Other arrangements could be made for the proprietor and higher-paid managers.

Further, low- and modest-wage working parents, realizing that they can get free or relatively inexpensive public coverage for themselves, their spouses and their children, would have strong incentives to seek employment with higher wages and no health benefits or to actively encourage their employer to drop the company health plan and raise workers' wages.

The reports from Rhode Island, referred to earlier, suggest that, even in the short run, coverage shifts could be significant. And in the longer run, as more employers and workers understand the significant financial gains made by their competitors and colleagues, the effect could mushroom.

How many employers would find it to their financial advantage to drop the coverage they now offer or significantly reduce their contribution towards it would depend on how many working parents could qualify for public coverage. In this regard, it is worth noting that the current eligibility threshold for public coverage (of children) in California is approaching median family income. As Table 12 shows, roughly *half* of California's nonelderly population have incomes below the current upper limit for the Healthy Families program (i.e., less than 250% FPG after taking into account maximum applicable deductions).

Table 12: Percent of Persons with Family Incomes Below Selected Percentages of FPG, With and Without Applicable Deductions, California, 1999

	Income After Deductions*		Income Before Deductions	
	<250% FPG	<200% FPG	<250% FPG	<200% FPG
Parents	48.6%	41.2%	45.5%	37.4%
Children	59.8%	52.6%	56.8%	48.9%
Non-Parents	44.1%	37.7%	42.6%	35.8%
TOTAL Nonelderly	50.5%	43.6%	48.1%	40.5%

* "Income After Deductions" was calculated by excluding from income amounts or kinds of income not countable under Medi-Cal and Healthy Families program rules. In particular, \$90 per worker per month was deducted for work expenses, as was \$175 per month for childcare expenses for children under age 13 (\$200 per month if the child was under age 2), unless there was a non-working parent in the home.

Source: IHPS analysis of the March 2000 Current Population Survey

The median income for families in California was \$46,500 in 1998.²² A family of four with two working parents and two children over age two in day care could have \$48,996 and still qualify

* The fact that employer coverage rates are lower for non-parents than for parents for all income levels above 100% FPG (see Table 1), combined with the fact that participation ("take-up") rates are similar when coverage is offered (see Table 2), suggests that non-parents more frequently choose jobs that do not offer health insurance.

for Healthy Families. With only one working parent and no childcare expenses, the family could earn \$43,716 and qualify.*

As the eligibility threshold for public coverage approaches median family income, many employers will have sizable numbers of workers who have families and meet income standards for public coverage. The more workers who could qualify for public coverage, the stronger the financial incentive will be for employers to drop the coverage they now offer or significantly to reduce their contribution towards it.

In addition, many low- and modest-income working families who currently have employer coverage would have strong incentives to drop it, particularly if they currently pay significant amounts of their paychecks for it.

As noted earlier, 29% of enrolled workers nationally had to pay more than 40% of the cost of family coverage in 1998.²³ That translates to about \$200 per month (or more) at current premium levels in California, or about 5% of income for a 4-person family at 250% FPG in 2000. Even the average family contribution required, now around \$120 per month,²⁴ may be difficult for low- and modest-income families.

Finally, and most importantly, state policy makers should carefully consider policy options that improve the signals public coverage of working parents would otherwise send to the private sector.

A public program that potentially offers coverage to a large segment of the state's working population signals employers to re-think their role in providing health insurance. Once public coverage is widely available, offering health insurance no longer provides a business with a competitive advantage in the labor market. In fact, any firm (with many low- and modest-wage workers) that does offer health insurance will now be disadvantaged relative to competing firms that enjoy lower costs and can offer higher wages to their workers who obtain coverage through the state program.

Employer response to the changed incentives will likely not be immediate, but it will increase over time. Firms that now offer health coverage may have to overcome the inertia of established expectations among their workers in order to cut back on the coverage they now offer. But new firms, of which there are many every year, would have no such history to overcome. If a high percentage of their work force is eligible for public coverage, new firms will question whether to offer coverage. Smaller firms, even if not new, are more able to respond quickly to changed incentives and to work out new compensation and benefits arrangements directly with their workers. Their workers could benefit substantially by negotiating a higher wage in lieu of

* The current upper income limit for Healthy Families is \$3,553 per month (per <http://www.healthyfamilies.ca.gov/Handbook/HBpg16.htm>, accessed December 13, 2000) or \$42,636 per year. To reach this income, work expenses of up to \$90 per worker per month and childcare expenses of up to \$175 per month per child may be deducted. These maximum allowable deductions total \$6,360 per year. Thus, the described family could have annual income as high as \$48,996 (= \$42,636 + \$6,360) and still qualify. With only one working parents, no childcare deductions are allowed, but the work expense deduction (\$1,080 annually for one worker) would still apply.

employer coverage. These firms, too, can be expected to respond to the changed incentives, once they become aware of them.

If policy makers wish to add to, rather than substitute for, existing coverage for parents with incomes up to 200% or 250% of poverty (approaching median income), they should take care in designing public programs. It would be prudent to seriously consider some combination of eligibility restrictions, sliding-scale, and/or wage-based contribution requirements and other policies that would encourage rather than undermine employment-based coverage, such as coordinating with existing employer coverage and encouraging development of new job-based coverage for workers and their families.

2. Eligibility Restrictions or “Firewalls”

Eligibility restrictions of various sorts, sometimes called “firewalls,” are intended to focus public coverage on those most in need of it and to discourage both employers and workers from dropping existing coverage, i.e., to avoid or reduce “crowd-out.” The primary firewalls, look-back periods and denying eligibility to those who have or recently had access to employer coverage, are discussed below.

- a. **Look-Back Periods**, which require applicants to have been without employment-based health insurance for some period of time in order to qualify for public coverage.

For example, the “MinnesotaCare” program (a Medicaid-based §1115 waiver program that covers parents and children up to 275% FPG) denies eligibility if an applicant has had Medicare or any form of private health insurance in the past four months, but also uses a longer, 18-month “look-back” period for access to employer-sponsored coverage. (MinnesotaCare will be discussed further in a moment.)

California already uses a short “look-back” period for children under its Healthy Families Program. Given the greater risk of “crowd-out” when public coverage is extended to working parents as well as children, and given the fact that the working parent (not the child) is the one who decides whether or not to enroll in employment-based coverage (when available), it is sensible to consider “look-back” periods for parents longer than three months. The longer the “look-back” period, the stronger the signal that the state expects employers to continue to “take care of their own.”

By requiring applicants to have been without employer coverage for six months or twelve months, the state could focus its resources on low-income families who are chronically uninsured and avoid bringing under the “public coverage” umbrella the larger number who are uninsured for a brief periods.

Furthermore, this requirement would help to prevent “escalating crowd-out”—a situation in which more and more low-income families come into the public program over time, even when the program is nominally limited to those who are completely “uninsured.” If people could qualify for public coverage shortly after having lost private coverage, crowd-out would be likely to escalate in the following way:

- During a period of being uninsured, low-income families could enroll in the public program. As the data on duration of “uninsurance” presented earlier (see Table 6 and Figure 1) showed, most of these families would have become insured again within six months in any event, most likely due to a change in job situation that made them eligible for employer-sponsored coverage.
- When they again became eligible for employment-based insurance, these families would have strong incentives to stay in the public program, for which they would probably have to pay a much smaller premium than their employee contribution requirement for family coverage.
- Thus, over time, many parents and children to whom employment-based coverage is available would continue to be enrolled in the public program, rather than in employment-based plans.

While most people who become uninsured stay uninsured for less than six months at a time, the vast majority of those uninsured in any given month have been without employment-based insurance for twelve months or longer (see Table 7). Thus, requiring applicants for public coverage to have been without employer coverage for six or twelve months would not exclude significant numbers of low-income parents who are now uninsured from eligibility for the program, but it would send a strong symbolic signal to both employers and workers not to drop existing employer coverage, thereby preventing “escalating crowd-out.” Any negative impact of such a “symbolic” restriction on needy families could be further limited by allowing appropriate exemptions (such as for lay-offs).

Administering such “look-backs” is likely to be difficult. One option, consistent with the concept that the most important role of look-backs is to signal policy intent, is simply to rely on self-declaration by the applicant. Real enforcement would mean that the state either (1) contact all former employers to verify that each applicant was not enrolled through employer-sponsored health insurance over the applicable period; or (2) require employers to report basic identifying information and level of coverage (worker-only or family) for all primary enrollees in any health insurance plan offered by the employer (as part of their income tax withholding or state unemployment insurance reports).

- b. **Denying eligibility for participation in the public program if employer coverage is available** (that meets certain standards), or was available to the applicant in the recent past.

In addition to its general four-month “look-back” period, MinnesotaCare also denies eligibility if an applicant either is now or was, during the past eighteen months, eligible for employer-subsidized coverage from their *current* employer. (Coverage is considered employer-subsidized if the employer pays at least 50% of the cost of health coverage for the employee, and where offered, for the dependent coverage.²⁵ Employer-sponsored coverage for which the employer pays less than 50% is not considered subsidized and therefore is not a barrier to enrollment.)

Note that eligibility is denied if an applicant’s current employer dropped subsidized coverage within the past eighteen months. This provision is intended to discourage employers from dropping existing their coverage (or reducing contributions below 50% of premium). However, if

the worker lost access to employer-subsidized coverage due to a job change and does not have access to employer-subsidized coverage through the current employer, eligibility is not denied. An exception is made for children with family incomes at or below 150% of poverty whose parents have employer-subsidized (or other) coverage that is judged to be “inadequate” by state standards.*

MinnesotaCare relies on self-declaration to verify current and past access to employer-subsidized coverage; however, if the applicant (employee) cannot answer all the necessary questions, employers are asked to provide the information.

Wisconsin’s BadgerCare program, which covers both children and parents, also denies eligibility if an applicant family either is now or was, during the past eighteen months, eligible to enroll in an employer-provided family health plan, but only when the current employer pays (or would pay) 80% or more of the family premium. Unlike MinnesotaCare, BadgerCare does not deny eligibility if the current employer discontinued health benefits to all employees.

Like MinnesotaCare, BadgerCare initially relies on self-declaration by the applicant. After the family is found eligible, however, BadgerCare follows up with every employer of BadgerCare family members to determine whether family members have had access during the previous eighteen months to family coverage where the employer would pay 80% or more. If the family is found to have such access, they are dropped from the program after notice.

3. Premium contribution requirements for public coverage.

Public programs achieve their highest participation rates when there is no charge for enrollment. If the public policy goal were simply to reach and cover the greatest number of uninsured families, regardless of cost, a no-premium policy would be most effective. But, as we have seen, there is great risk that a free public program would be very expensive because it would be attractive to many low- and modest-income families who currently have employer-sponsored health insurance.

Charging premiums is one way of overcoming the perception that public coverage is “free.” California currently charges modest premiums to enroll children in Healthy Families. Several approaches to premiums are presented below.

a. Sliding-scale premiums

Sliding-scale premiums that increase with family income or workers’ wages could encourage working families to take advantage of available employer-provided coverage while maintaining access to public coverage for working families that cannot get employer coverage.

Because the lowest-income families are already eligible for free Medi-Cal coverage, it might be appropriate to charge every (working) family applying for Healthy Families a premium of somewhere between \$10 and \$30 per month per adult, plus the current Healthy Families (minimum) premium of \$4 or \$7 per month per child (depending on the plan chosen).

* Health coverage is considered “inadequate” for children if it lacks two or more of the following types of coverage: basic hospital, medical-surgical, prescription drugs, dental, or vision.

Families with higher income (or wages) would be charged more. How much more is a critical design issue. The premium could be based simply on a percent of income (or wages). Or a maximum premium could be established, payable by families with incomes at the top of the eligibility range for the program. Between the minimum and the maximum premium, a formal “sliding scale” would be developed.

Establishing appropriate premium levels is an exercise in trade-offs. Premiums need to be low enough to encourage participation by those without other access to coverage but high enough to discourage those who have reasonable access to employer coverage from declining it and enrolling in the public program. In evaluating the incentives faced by working parents who do now have access to employer coverage, it is important to consider both the average or median worker contribution for employment-based family coverage and the full cost of typical employment-based family coverage in California. At small firms, particularly, employers and workers are well aware of the direct trade-off between wages and benefits like health insurance.

b. Basing contribution requirements on individual earnings rather than family income.

A detailed analysis of alternative premium structures is beyond the scope of this report. However, we think it is important to point out that sliding-scale or percentage premiums or contribution requirements need not be based on total family income. Instead, they could be based on each working parent’s individual wages. The rationale for this alternative approach is that wage (earnings) levels of workers are strongly related to the likelihood they have employer coverage. For example, nine of ten parents earning \$30,000 to \$39,999 have employer coverage (see Table 8), compared to six of ten parents with earnings of \$15,000 to \$19,999. About one in five California working parents with net family income in the 133%-199% FPG range has earnings over \$30,000 (see Table 9).^{*} One approach to targeting public subsidies to parents who are more likely to be uninsured, then, is to relate the amount of subsidy to individual parents’ earnings.

Many policy makers understandably view federal poverty guidelines and other objective standards as the best measure of need. A policy that bases contributions for public coverage on individual earnings could create a more effective and workable interface with employment-based coverage. Although such policy is not typically found in a means-tested program, it would not be without precedent. A number of other well-established public programs—from Social Security to Medicare to workers’ compensation programs—base contributions on workers’ wage levels.

This approach would be consistent with market forces and equity in the workplace. Labor economists generally agree that wages and (health and other) employer-financed benefits are interchangeable. For example, a worker earning \$38,000 with an employer health insurance contribution of \$4,000 toward family coverage could generally earn \$42,000 instead in a comparable job without such benefits. Requiring a premium contribution that increases with wage level would make it less likely that people would drop employer coverage or switch jobs to qualify for publicly financed coverage while gaining increased wages. And it would reduce the degree to which the state, through public coverage, would be giving a competitive advantage to employers who do not pay for health insurance over those who do.

^{*} These are typically families in which one parent accounts for most or all of the earnings.

Since the Healthy Families application already requires the earnings of each parent to be reported separately, such an approach may not be as administratively burdensome as might at first appear. Eligibility would continue to be based on family income as a percent of poverty, while required contributions for each parent would be based on their respective (individual) earnings, not on total family income. The contribution schedule would be designed so that a family with two low-wage workers (who are less likely to have access to employer-sponsored coverage) would pay a lower total contribution than a family at the same % FPG with one higher-wage worker (who is more likely to have access to employer coverage). Thus, families with two low-wage workers who do not have employer-financed coverage need not be penalized (relative to a contribution requirement based on family income).

To illustrate the concept, we describe a simple hypothetical policy scenario and present associated contribution examples. For each adult, the premium could be \$10 per month plus 5% of that adult's earnings over \$1,000 per month. (Although each family would also have covered children, children's premiums are not included in this simple example.) Under this premium schedule, a single parent earning \$1,250 per month (\$15,000 per year or about \$7.50 per hour) would contribute \$22.50 per month for coverage [$\$10 + 0.05 * (\$1,250 - \$1,000)$]. A couple, each of whom earned \$1,250 per month, would contribute \$22.50 per month each, or a total of \$45 per month for parents' coverage. A sole-earner spouse earning \$2,500 per month (\$30,000 per year or about \$15 per hour) would contribute \$85 per month for coverage, while the premium for the non-working spouse would be only \$10 per month, for a total of \$95 per month. Note that, although the two families earn the same total amount, the family with a single earner, who is much more likely to have access to employer coverage, pays a premium contribution more than twice as large does as the two-earner family, in which neither low-wage worker is likely to have access to employer coverage.

This simple illustrative structure would likely need to be altered to better align incentives.* While detailed policy proposals are beyond the scope of this paper, our simple example clearly illustrates the potential impact of a wage-based contribution schedule. In particular, it would result in some parents contributing more than other parents with similar household incomes. While this would be viewed as unfair from a traditional social welfare program perspective, it is arguably more fair in the context of workers' total earnings and its effect on employers who do and do not provide coverage and on their respective employees. It would also better target coverage to those least likely to have private employer coverage and better avoid incentives for employers and workers to drop such coverage.

Further, compared to many of the eligibility restrictions that are designed to avoid crowd-out, this policy would be more easily enforced. Instead of establishing huge economic counter-

* For example, policy makers will want to compare the contribution amounts generated by any formula at the upper limits of the eligible wage range with private-market premiums to examine whether the incentives thus created are appropriate. Also, as presented, this premium approach could sharply reduce incentives for the working parent to decline coverage available from her own employer, but create large incentives for her spouse to obtain (free) coverage from the Healthy Families program. Since one worthy policy objective is to facilitate rather than discourage single-source coverage for families, it would be sensible to investigate further refinements in such a policy approach. For example, contribution requirements could be divided equally between for spouses in the single earner families, or higher minimum contribution requirements could be established for all parents in non-poor families.

initiatives to private employer-based coverage, it improves those incentives with an approach more compatible with labor market dynamics.

4. Coordinating with Employer-Sponsored Coverage

- a. Buying-in to existing employer coverage (“premium assistance” or “purchasing credits”)

As noted earlier (see Table 3), a not insignificant percentage of low- and modest-income parents who are uninsured have been offered coverage by their employer but have declined it (either for their dependents or for the entire family). In most cases, they did so presumably because they could not afford their share of the premium. Other parents may prioritize competing needs above health insurance. Subsidizing enrollment in employer coverage for uninsured low- and modest-income working families could induce some portion of these uninsured working parents to accept the coverage offered by their employer.

A “buy-in” or “premium assistance” approach (called “purchasing credit” under California’s Healthy Families program) offers both a way to access available employer contributions, as well as an alternative to denying eligibility for public help when an otherwise-eligible family has not taken advantage of access to employer-sponsored coverage. As a condition of eligibility for assistance, these applicants could be required to accept employer coverage that is offered to them (if it meets appropriate standards and is cost-effective) but they would receive public subsidies to enable them to afford their employer’s coverage.

Instead of encouraging “crowd-out,” a premium assistance program of this sort would encourage use of employer coverage and would enable the state to tap into employer contributions that are currently available, but not being used, on behalf of low- and modest-income families. It would also help to avoid the “escalating crowd-out” phenomenon discussed earlier because it would allow eligible families to enroll in employment-based coverage that becomes available to them, while paying only an amount comparable to the premium for the public program.

When certain conditions are met, Wisconsin’s BadgerCare program will pay the premium necessary to enroll a family in the employer-sponsored plan (assuming the plan meets other requirements, including being more cost-effective for the state than providing direct public coverage). This program pertains when a currently uninsured applicant family has access to employer-sponsored family coverage for which the employer pays between 60% and 80% of the family premium, and the family is otherwise eligible.

Wisconsin has found this “employer buy-in” program to be a resource-intensive effort that has realized very little enrollment under current federal SCHIP regulatory guidelines. Nevertheless, Wisconsin still believes it is a sensible way to support continuity of care, maximize use of private funds and, potentially, strengthen employer groups. Although enrollment is minimal, this program, and associated eligibility standards that screen out those with access to employer contributions of 80% or more for family coverage, reinforce the signal that the state encourages job-based coverage.

Based on data collected from applicants’ employers, Wisconsin officials believe that, by including employer plans with lower than 60% employer contributions toward family premiums,

participation will improve. (Almost as many applicants with access to employer coverage have been found to have employer contributions in the 50%-to-59%-of-premium range as in the [currently qualifying] 60%-to-79%-of-premium range.²⁶)

While employers who contribute under 50% or 60% towards family coverage might make little or no net contribution for children beyond their worker only contribution, they often make a substantial contribution available for the parent(s). Thus, buying into employer-sponsored family coverage can often be cost-effective when the state would otherwise finance the entire cost of covering the parents as well as the children, even though it would not be cost-effective if the state otherwise paid only the children's coverage. For example, an employer might contribute \$2,800 (about 47%) toward family coverage costing \$6,000, even though that is no more than the employer would contribute towards worker-plus-spouse coverage only.

While fairly obvious, this is an important observation. Uninsured persons who decline available employer coverage almost certainly have lower employer contributions available (and thus face higher employee contribution requirements) than do people of comparable incomes who are insured through their employers.

Some who support public program expansions oppose implementation of purchasing credits for employer coverage. They posit that employers and workers are more likely to use such a program to re-finance their existing private coverage than they are to shift their source of coverage to the public program. If nothing else, the limited enrollment in programs such as those in Wisconsin and Oregon indicates that employer-coverage buy-in programs can be implemented without triggering a massive rush among workers and employers to re-finance their existing employment-based coverage.

Moreover, states that have implemented premium assistance initiatives thus far, including Oregon and Massachusetts, adopted them in large measure to support and maintain the viability of private employment-based coverage and thus minimize "crowd-out" over the long term.²⁷ Rhode Island policy makers recently added a premium assistance program to quell the crowd-out that was occurring from their earlier public-program-only expansion.

That said, even if there is interest in a premium assistance (purchasing credit) initiative, it is reasonable to be concerned that a program such as Healthy Families does not have the staff resources or the existing market role and infrastructure to design and implement an effective purchasing credit program on its own. This concern is further justified given the very limited enrollment in the handful of states that have implemented SCHIP premium assistance thus far (although a few states have achieved reasonable enrollment in Medicaid, §1115-waiver or state-only premium assistance programs). It seems likely, however, that these problems could be overcome by identifying and working with "strategic partners" in the private sector who have the desire and capacity to bring collaborative public-private financing efforts to fruition in the near term.

* While no data now available (to the best of our knowledge) can demonstrate conclusively that this hypothesis is correct, both economic common sense and the data previously presented in this report strongly suggest that it is accurate.

The most promising strategic partners would have market roles that give them the potential to reach a significant number of uninsured children (or families) through job-based coverage. They also would have, or could access, the administrative capability to handle Healthy Families requirements such as offering supplemental or wraparound coverage to meet SCHIP benefit requirements, tracking employer contribution levels and verifying ongoing enrollment of subsidy recipients. Appropriate partners should be fully committed to covering uninsured parents and children, and to not refinancing existing private coverage with public dollars.

Moreover, working with private organizations that have the appropriate capacity and roles, such as health plans and purchasing pools, will help to minimize the risk of crowd-out by keeping employers' involvement in the purchasing-credit approach to a bare minimum. These non-employer private contractors would provide the necessary information to the state about benefit coverage and employer contribution levels for the employers they deal with, and could even track employer contribution rates over time to help assure that "crowd-out" does not occur.

California may have a unique opportunity to successfully pursue such a strategic-partner approach. Organizations such as Blue Cross of California,^{*} Pacific Health Advantage (formerly the Health Insurance Plan of California) for small employers,[†] and its parent, the Pacific Business Group on Health, for large employers,[‡] have the necessary market roles and expertise and have expressed interest in pursuing the "purchasing credit" option under Healthy Families. Other potential strategic partners may express interest as the concept becomes better known.

- b. Expanding job-based health insurance to more workers: building on job-based coverage through small, low-wage firms.

As noted earlier, many policy makers believe that work-based coverage is an important part of a broader strategy to improve the economic situation of low-income working families. If California policy makers wish to reinforce the expectation for and benefits of job-based coverage, alternative coverage expansion approaches may be desirable as an adjunct to Healthy Families expansion. It may be advantageous to make a portion of the new coverage funds

^{*} Blue Cross of California has the capacity to perform all of the roles outlined for a "strategic partner;" and, because of its concerns regarding potential crowd-out and its interest in maintaining privately financed employer coverage for working populations, it has indicated its willingness to consider undertaking the administrative burdens involved in administering a purchasing credit program for uninsured parents and children who have declined coverage available from an employer group insured by Blue Cross.

[†] The program's needs for coordinating with small employers (including, potentially, previously uninsured small employers as discussed later) could be relatively readily served by the structure of PacAdvantage (PBGH's market name for the formerly state-run Health Insurance Plan of California). PacAdvantage already has standardized benefit plans across competing carriers, so establishing supplemental packages to meet federal and state guidelines would be relatively straightforward. And PacAdvantage already holds health plan contracts (on behalf of employers) and pays plans from revenues collected from multiple financing sources, so adding supplemental contracts and state subsidies to the revenue mix it already administers should be straightforward as well.

[‡] It is worth noting that premium assistance programs should not focus attention solely on small-firm workers. Many uninsured working parents who have access to employer coverage are likely to work for larger firms as well. Analysis of California data from the 1998 MEPS-IC employer survey shows that, of workers not covered through their own job (who may be insured elsewhere), about 3/4s of those not covered because their employer does not offer coverage to anyone work for small firms (50 or fewer employees), while about 3/4s of those who declined coverage actually offered by their employer work for large firms (more than 50 employees).

available for innovative arrangements aimed at making work-based coverage available through businesses that have not traditionally sponsored health insurance coverage. Public funding for coverage of parents as well as children would provide a better platform than would children-only dollars to develop such approaches for work-based coverage of uninsured working families.

But here again, some policy makers are understandably concerned that close collaboration between public programs and employers with respect to health insurance subsidies will lead to greater “crowd-out” of employer contributions by making employers more aware that public funds are available.

There is, however, a simple-to-define subset of employers that almost never offer health insurance coverage to their workers. Demonstration approaches focused on this subset of employers would run little risk of “crowding out” existing employer contributions. Specifically, small firms that have a majority of low-wage workers rarely offer coverage to any of their workers: Nationwide, only 21.6% of businesses with fewer than 50 workers and a majority low-wage workforce offer health insurance to any of their workers, compared to 50% of small businesses with a higher wage profile and 96.3% of businesses with 50 or more employees. (Weighted by workers, the figures are 32.7%, 71.6% and 97.5%, respectively.)²⁸

The few that do offer coverage are very likely to drop that coverage in the near future, no doubt because they and their employees simply can’t afford to sustain it. Regardless of wage structure, one-fifth of the smallest firms—fewer than 10 workers—that offered coverage in 1995 had dropped it by 1997, per RAND’s analysis of the Robert Wood Johnson Foundation’s 1997 Employer Survey.²⁹ Unpublished, preliminary analyses by RAND of the same survey indicate that, among low-wage firms (of all sizes) that offered coverage in 1995, 28% had dropped it by 1997. (This is more than double the 12% “drop-rate” for non-low-wage firms of all sizes.)

Therefore, offering heavily subsidized coverage to parents who work in such firms (and who therefore very rarely have coverage available to them) presents only an inconsequential danger of crowd-out,^{*} and would afford the opportunity to develop new ways to coordinate public and private financing and coverage vehicles.

To accomplish this, it would make sense to reach working families where their low-wage firms apply to participate and meet applicable criteria. These employers could provide a working-family-friendly place of enrollment, while reinforcing the expectation that workers and their families receive coverage through the workplace. This approach might substantially improve coverage rates of eligible workers who are reluctant to participate in public programs. If carefully framed, it could thus reinforce, rather than undermine, social and market expectations for employment-based coverage. And by offering health coverage through the workplace, so that low-wage families could retain their source of coverage as earnings increase, pilot initiatives might demonstrate innovative ways to reinforce the welfare-reform objectives of encouraging work and career development.³⁰

This sort of initiative would also allow unsubsidized higher wage workers in low-wage firms to benefit from more cost-effective employer-group coverage. Although coverage for these workers

^{*} And, to the extent crowd-out did occur, it would likely result in higher wages for a very low-income population.

would be paid for entirely with employer and employee contributions, not with public subsidies, the participation of (subsidized) lower wage workers would allow the business to offer group coverage, which all employees, not just those receiving subsidies, would benefit from.*

But uninsured small employers with mostly low-wage workers will most often not want to undertake substantial new administrative roles, create an expectation (on the part of their workers) that they will pay for low-wage workers' coverage, or act as the plan sponsor who selects a carrier and purchases coverage for these workers. Therefore, creative new approaches will be needed to encourage these employers to participate. Alternative paradigms for reaching uninsured persons through low-wage small firms might be explored on a demonstration basis as a component of an §1115 waiver for coverage of parents.

One example would be to allow promising local or other targeted pilot program(s) where funds are also available to subsidize coverage of childless coworkers of Healthy Families parents. For example, CalOPTIMA in Orange County is working with other local community stakeholders to develop approaches to promote greater job-based coverage within the county. Ideas under consideration by the local community group include an approach targeted at uninsured low-income workers in uninsured small businesses and their families that would leverage Healthy Families funds for Healthy-Families eligibles. CalOPTIMA's provider-based delivery model has substantial promise as a way to reach populations, such as Latinos, who have been difficult to reach through conventional health plans/insurance, but who value regular access to a provider such as a clinic. Non-subsidized employees in these currently uninsured firms might also find CalOPTIMA's provider-based choice model attractive, or they might prefer to select one of the HMOs offered through CalOPTIMA. (In its role as Medi-Cal administrator for Orange County, CalOPTIMA already offers such choices to Medi-Cal enrollees.) Thus, CalOPTIMA should be an attractive vehicle for job-based coverage options for currently uninsured small business workers and their families.

MRMIB could also contract with other organizations that have the mission and capacity to implement such pilots, and an administrative and benefit structure that would allow cost-effective coverage. For example, Pacific Health Advantage (formerly the Health Insurance Plan of California) already has the capacity to enroll small-firm workers in their choice of standardized benefit health plans, to collect premium contributions from multiple sources, etc. This core structure would lend itself well to coordinating supplemental benefits and subsidies applicable under Healthy Families. While subsidies might still pertain only to working parents and children, more low-wage employers with a number of childless workers might be likely to participate than they would in a public program. And the state might want to pursue a §1115 waiver for such a small-scale demonstration that includes childless workers.

Or, the Healthy Families program could make its own plans available through low-wage small employers and retain an administrative vendor with experience and capacity to handle enrollment and premium collection from employer groups. Given MRMIB's previous experience with the

* Health plans and insurers require that a specified percentage of an employer's work force must agree to participate before the insurer will offer the employer a group plan. Low-wage workers typically decline to participate if they have to pay very much at all for the coverage. If few low-wage workers choose to participate, the employer cannot offer group coverage to any of its workers.

HIPC, applicable staff expertise should be available, although this would entail a substantial diversion from other priorities.

Through one or more pilot initiatives such as these, the state might facilitate innovative ways to reach low-income families while reinforcing employment-based coverage as well as encouraging job stability and continuity of care for those covered. Depending on the model developed, the cost per Healthy Families eligible person could be higher than through the public program. Even in this case, if the initiative also is successful in bringing non-subsidized, previously uninsured co-workers into coverage, and if it helps to avoid a broader shift from employer to public coverage, it could nevertheless be very cost-effective from a broader perspective.

It is important to note that, unless demonstration or other funds were available for childless low-wage workers, financing for their coverage would have to come entirely from their employers and the workers themselves. Without such “outside” funds (which our preliminary analysis indicates could be very modest relative to outlays for family and unsubsidized worker coverage), the program might be attractive only to low-wage firms who happen to have a majority of workers who are parents. If so, the efficacy of the approach could be severely compromised.

5. Conclusion

As California expands its Healthy Families Program to cover uninsured low-income parents, it is important to do so in way that does not result in public funds going largely to replace existing private employer coverage.

While difficult decisions need to be made to avoid or overcome strong economic counter-incentives, policies can be designed that will extend public coverage to parents and children who need it while at the same time maintaining or expanding private employment-based coverage.

This report has presented data, analyses and policy options with the aim of helping policy makers to successfully achieve coverage of many of the state’s uninsured working families.

ENDNOTES

¹ By November 2000, 51,172 additional children were enrolled in Medicaid and BadgerCare. Both (new) Medicaid and BadgerCare children are counted because when parents apply for BadgerCare, often some of the children end up being eligible for Medicaid. This figure is compared to an estimated 54,000 children in families under 200% FPG who were uninsured in July 1999, according to the Wisconsin Family Health Survey. Similarly, the 51,438 adults now covered by BadgerCare (in November 2000) represent about 57% of the estimated 90,000 uninsured parents in families under 200% FPG in July 1999. It should be noted that turnover in the BadgerCare caseload is significant. For example, as of the end of the first full year of operation, 69,322 individuals (adults and children) were enrolled in BadgerCare; but the unduplicated enrollment in BadgerCare over that first year was over 100,000 individuals. (Detailed information in support of Secretary Leean's summary statement provided by Russell Pederson of the Wisconsin Department of Health and Family Services, January 2, 2001.)

² Presentation by Joe Leean, Secretary, Wisconsin Department of Health and Family Services, on December 11, 2000, at a Washington, DC conference sponsored by The Commonwealth Fund, and subsequent personal conversations with Mr. Leean by the authors.

³ Karla Hanson, "Is Insurance for Children Enough? The Link Between Parents' and Children's Health Care Revisited." *Inquiry* 35:294-302 (Fall 1998).

⁴ Because it always assigns the maximum allowable deductions, our "net income" approach generally overestimates deductions and thus underestimates "true" income for program purposes. Some families will appear to be eligible when they are not. These higher-income families have greater rates of EBI. Therefore, our "net income" approach will tend to somewhat overstate the availability of employer coverage to families in each "% FPG" category. Conversely, because it ignores deductions, our "total income" approach overestimates "true" income for program purposes. Some families will appear not to be eligible when in fact they are eligible. But these families do have higher incomes, and therefore are more likely to have EBI, than families who meet the eligibility criteria without deductions. Excluding them, therefore, will tend to understate the availability of employer coverage to families in each "% FPG" category.

⁵ Estimates of the number of parents and children with access to employer coverage are not available from the Current Population Survey (CPS). The data presented here are national estimates from the 1996 Medical Expenditure Panel Survey (MEPS) household survey. Access data at the State level and are not available in the publicly released MEPS household data.

⁶ See previous note.

⁷ Data on the duration of "uninsurance" are not available at the State level and are not available from the Current Population Survey (CPS). The data presented here are national estimates from the 1996 Medical Expenditure Panel Survey (MEPS) household survey. Unlike the CPS, which asks about health insurance coverage over the entire preceding year, MEPS asks about insurance status for each month in the year and thus can produce month-by-month estimates of insurance status.

⁸ Robert L. Bennefield, "Who Loses Coverage and for How Long?" Dynamics of Economic Well-Being: Health Insurance, 1993 to 1995. Current Population Report P70-64. U.S. Census Bureau, August 1998. Figure 4.

⁹ Robert L. Bennefield, "Who Loses Coverage and for How Long?" Dynamics of Economic Well-Being: Health Insurance, 1993 to 1995. Current Population Report P70-64. U.S. Census Bureau, August 1998. Table 1. (Detailed table not in published report accessed from <http://www.census.gov/hhes/hlthins/hlth9394.html>, December 13, 2000.)

¹⁰ Nationwide in 1997, only 17.3% of small firms (fewer than 50 employees) with a majority of low-wage workers offered health insurance coverage, compared to 47.6% of other small firms. Agency for Healthcare Research and Quality. Medical Expenditure Panel Survey Insurance Component, 1997. Table I.A.2. (www.meps.ahrq.gov)

¹¹ Philip F. Cooper and Barbara Steinberg Schone, "More Offers, Fewer Takers for Employment-Based Health Insurance: 1987 and 1996," *Health Affairs* (November/December 1997):142-149. Exhibit 2. At these wage levels, offer and take-up rates were even higher when employers of all family members were considered.

¹² The 1998 MEPS-IC found that workers in California who actually enrolled in full family coverage paid an average of \$109 per month for that coverage, slightly less than the national average of \$115 per month. On average,

the worker's contribution represented 24.1% of the total family premium in California, and 24.7% nationally. Agency for Healthcare Research and Quality, MEPS-IC 1998, Tables II.D.2. and II.D.3.

¹³ The 1999 Kaiser/HRET/UC Berkeley California Employer Survey found that family coverage cost workers an average of \$115 monthly in California, compared to \$145 nationally, representing 24% and 32% of the total premium, respectively. Kaiser Family Foundation. Chart Pack for the 1999 California Employer Survey (<http://www.kff.org/content/2000/1568/>), Chart 9. The large difference in the national average worker's contribution toward family coverage between this survey and the MEPS-IC suggests there are discrepancies between the two surveys. The most obvious is that the KFF/HRET survey omits employers with only one or two workers.

¹⁴ Unpublished tabulations of the Kaiser/HRET/UC Berkeley 1999 California Employer Survey performed for IHPS by the UC Berkeley Center for Health and Public Policy Studies.

¹⁵ Stephen H. Long and M. Susan Marquis, "Stability and Variation in Employment-Based Health Insurance Coverage, 1993-1997," *Health Affairs* (November/December 1999):133-139. Exhibit 4.

¹⁶ Special tabulations of the Kaiser/HRET/UC Berkeley 1999 California Employer Survey, previously done for IHPS and California's Managed Risk Medical Insurance Board by the Center for Health and Public Policy Studies at UC Berkeley, show that the median employer contribution for family coverage was highest—80.7%—at relatively high-wage firms (fewer than 10% of workers earn less than \$20,000 annually). At firms with a high percentage of low-wage workers (35% or more earn less than \$20,000), the median employer contribution was 11 points lower—69.4%. At almost one in four (23.3% of) low-wage firms, the employer paid less than 60% of the cost of family coverage. The same unpublished study found similar variation by firm size. At large California firms (1,000 or more workers), the median employer contribution for family coverage was 78.6%. But the median contribution at small firms (3 to 50 workers) was 10 points lower—68.4%.

¹⁷ A group of States recently requested special tabulations of the MEPS-IC to obtain information on worker contributions for family coverage (both averages and distributions) that will better reflect the contribution requirements faced by all workers eligible for coverage, not just by those who actually enrolled. This data is expected to become available early in 2001.

¹⁸ Long and Marquis, *op.cit.*

¹⁹ Christopher Rowland, "Officials rethinking RIte Care's mission," *The Providence Journal*, May 21, 2000.

²⁰ The Kaiser/HRET/UC Berkeley 1999 California Employer Survey found an average family premium of about \$5,500. For 2000, the Kaiser/HRET Employer Survey found a national average premium increase of 10.6% for family coverage. Applying this rate of increase to the 1999 California figure yields a 2000 estimate for California of \$6,080. The Kaiser California family premium estimate for 1999 is very close to the \$5,441 estimate for California in 1998 from the federal government's Medical Expenditure Panel Survey – Insurance Component (MEPS-IC) (www.meps.ahrq.gov/mepsdata/ic/1998/Index298.htm, Table II.D.1.)

²¹ Data from the Agency for Healthcare Research and Quality's 1998 MEPS-IC Survey of Private-Sector Business Establishments (hereafter, "MEPS-IC 1998") (www.meps.ahrq.gov/mepsdata/ic/1998/Index298.htm, Tables I.D.3). The average California worker with family coverage receives a 75.9% contribution from his employer. (Table II.D.3.)

²² California Department of Finance, Median Household and Family Income, California (updated April 20, 2000). Accessed October 31, 2000, from www.dof.ca.gov/HTML/FS_DATA/LatestEconData/FS_Income.htm. This is the most recent median income data available. It is presumably based on income of families as defined in the Census Bureau's Current Population Survey, which differ from the family definition ("family insurance unit") used in this report.

²³ Long and Marquis, *op.cit.*

²⁴ The Kaiser/HRET/UC Berkeley 1999 California Employer Survey found that worker contributions for family coverage averaged \$117 per month in 1999, or 24% of total premium. Kaiser/HRET/UC Berkeley 1999 California Employer Survey "Chart Pack," Chart #9. [Downloaded from www.kff.org/]

²⁵ If an employer pays 50% of premium for the employee but makes no contribution towards dependent coverage, then the employee would not be eligible for MinnesotaCare, but the worker's spouse and children would be eligible (assuming the spouse does not have access through his/her own employment).

²⁶ Of 1,465 applicants whose employers reported sponsoring a plan that meets basic HIPAA requirements, 22.5% had employers who contributed between 60% and 79% of premium, while 20.7% had employers who contributed between 50% and 59% of premium. For fully half of these applicants, the employer contributed less than 50% of premium, while only 7% had employers who contributed 80% or more. Data from the Wisconsin Department of Health and Family Services' EVIC (Employer Verification of Insurance Coverage) system as of October 31, 2000. Internal report provided to the authors by Don Schneider of DFHS staff on December 15, 2000.

²⁷ See, e.g., "State Policy Perspectives," Section I.C in *Coordinating State Children's Health Insurance Program with Employer-Based Coverage: Design and Implementation of Premium Assistance Programs*, Washington, D.C.: Institute for Health Policy Solutions, February 2000. (Available at www.ihps.org.)

²⁸ MEPS 1998. Tables I.A.2 and I.B.2.

²⁹ Long and Marquis, *op.cit.* Exhibit 3.

³⁰ A burdensome and difficult alternative would be to allow parents to indicate in the routine Healthy Families application that they believe their employer may meet the applicable criteria, and attempt to verify the wage composition and size of the employer of such applicants. In addition to obvious administrative burdens for many employers who would not qualify, this process approach would doubtless make the program seem especially inequitable to applicants who didn't qualify.