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CHCF Issue Brief

Weighed Down: Californians and the Financial Burden of Health Care Coverage

With implementation of the Affordable Care Act (ACA) in 2014, many Americans have obtained health insurance with the help of public coverage, through expanded Medicaid eligibility for people with low incomes and through government subsidies to make private individual-market coverage more affordable for people with moderate incomes. While the ACA dramatically reduced uninsured rates in the US and in California, affordability of health insurance and health care continue to pose challenges for many people.

This issue brief explores the affordability of health coverage in California in 2018, the latest year for which data are available, with a particular focus on health insurance deductibles and on who reports the greatest affordability challenges. It also explores what data suggest about some of the consequences of those challenges, such as taking on credit card debt to pay medical bills and trouble paying for basic necessities, including food and housing. Where possible, this issue brief compares data in 2018 to 2013, the last year before full implementation of the ACA, to assess trends under the ACA.

The COVID-19 pandemic emerged in California when this issue brief was being written. Affordability is one of many important factors that may shape Californians' willingness to seek, and their ability to obtain, the health care they need during this public health crisis. While the data analyzed here precede the pandemic, they paint a picture of important trends in Californians' ability to afford health care coverage and care a little more than a year before the pandemic hit.

California Health Insurance Reforms

Recently, California also has taken steps aimed at further bolstering the affordability of health care and insurance within the state. After Congress eliminated the tax penalty designed to enforce the individual mandate for people to obtain health insurance, California enacted its own individual mandate penalty. This state-level policy was designed to encourage more people to enroll in health coverage, enhancing the stability of California's health insurance individual market and preventing a scenario where healthy people opt out of purchasing health insurance, which could cause premiums to increase.*

Additionally, due to concerns that individual-market coverage still wasn't sufficiently affordable for people with incomes above the ACA's income limit of 400% of the federal poverty guidelines (FPG), as well as some with incomes below 400% FPG, California enacted its own individual-market subsidies for people purchasing coverage through Covered California. Because both of those California policies begin in 2020, this issue brief doesn't account for their impacts on affordability of health insurance in the state. To understand their impacts, it will be important to continue monitoring affordability in California in the coming years.

**Uninsurance Rates for California in 2013 and 2014* (PDF), State Health Access Data Assistance Center (SHADAC), n.d.

Introduction

The ACA created two new main pathways for people with low and moderate incomes to obtain health insurance: First, the law gave states the option to expand Medicaid (called Medi-Cal in California) to US citizens and certain lawfully present immigrants with incomes up to 138% of the federal poverty guidelines (FPG) (see Table 1 for FPG figures). Second, it created new marketplaces where people (again, limited to US citizens and certain lawfully present immigrants) could purchase individual-market health insurance and where people with incomes between 139% and 400% of FPG could receive government subsidies to reduce the amount they pay in monthly premiums. Additionally, people with incomes from 139% to 250% of FPG are eligible for further cost-sharing subsidies to reduce their out-of-pocket medical expenses, such as deductibles and copays.

Since the ACA's health insurance coverage expansions were implemented in 2014, uninsured rates in the US and California have dropped significantly.[1] However, many people continue to report spending large shares of their income on health insurance and health care, and that those costs impose tangible burdens, such as causing people to rely on credit card debt to pay medical bills and making it difficult to afford other basic needs, such as food and housing. Though not examined in this brief, it also is important to recognize that health care affordability can itself have health consequences. A recent survey by the California Health Care Foundation and the survey firm SSRS found that half of Californians reported skipping or postponing health care due to cost, and nearly half of those reported that made their condition worse.[2]

Table 1. 2020 US Poverty Guidelines, by Number in Household

	PERCENTAGE OF FEDERAL POVERTY LEVEL					
	100%	138%	150%	200%	250%	400%
1	$12,760	$17,609	$19,140	$25,520	$31,900	$51,040
2	$17,240	$23,791	$25,860	$34,480	$43,100	$68,960
3	$21,720	$29,974	$32,580	$43,440	$54,300	$86,880
4	$26,200	$36,156	$39,300	$52,400	$65,500	$104,800

Source: US Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation, "Poverty Guidelines," January 8, 2020.

To understand issues of health care and insurance affordability in California, several measures of affordability were studied from the California Health Interview Survey (CHIS), which asks people from throughout the state a variety of questions about health insurance and health care, including issues about cost and challenges of affordability. Multiple measures of affordability were studied, looking for statistically significant changes over time (between 2013 and 2018 and between 2017 and 2018) and between certain demographic groups and the overall state population. Measures examined include:

- Health insurance deductibles
  - What shares of Californians report having health insurance deductibles of at least $2,000?
- Trouble paying medical bills
  - What proportions of Californians say they have trouble paying medical bills?
- Medical bill–related credit card debt and difficulty paying for basic necessities among those reporting trouble paying medical bills
  - What shares of Californians report using credit card debt to finance medical bills, and how much debt do they incur?
  - What shares of Californians report that trouble paying medical bills causes them difficulties in affording basic necessities, such as housing and food?

Affordability Within California

While this brief focuses primarily on measures of affordability in 2018 across different demographic groups, statistical testing was also conducted for some changes over time. Testing for statistically significant changes between 2017 and 2018 for all the measures was performed, but those findings are not discussed in detail because no significant changes were found. In the absence of major intervening circumstances, such as substantial changes in health programs or dramatic changes in economic conditions, single-year changes in affordability tend to be relatively small, so it is not surprising that no significant changes were found for that one-year period. However, because data from 2013 were available for the deductibles measure (unlike the other measures), statistical testing was able to be conducted for changes between that final year before implementation of the ACA's coverage expansion and 2018. Statistically significant changes were found from 2013 to 2018 and are discussed below.

Health Insurance Deductibles of More Than $2,000

Health insurance deductibles are important in understanding the affordability of health insurance and health care. A health insurance deductible is the amount of out-of-pocket costs that enrollees must pay before the insurer begins to pay claims. For instance, if a patient with a $2,000 deductible were hospitalized for an injury or illness, the patient would need to pay the first $2,000 in bills before the insurer began to pay any of its share. Health insurance deductibles raise particular concerns when they exceed the ability of enrollees to readily pay them, such as in the case of "high deductibles" for people with lower incomes, who may face difficulties affording even modest deductibles. When deductibles are unaffordable, people may go without needed medical care or may experience downstream financial impacts, such as medical debt or trouble paying other bills, which are examined later through other measures.

Growing Share of Californians Have Large Deductibles

While there are different definitions for what makes a large deductible, focus was placed on a measure from the CHIS on rates of Californians who said they had a deductible of more than $2,000. For the overall population of California (with employer-sponsored insurance [ESI] and individual-market coverage), 31% of people reported a deductible of more than $2,000 in 2018, which was roughly double the rate of 16% in 2013 — a statistically significant difference.[3]

A more granular focus on different demographic groups within California revealed that rates of deductibles more than $2,000 increased significantly for many subgroups. Those included people from all income levels (up to 138% of FPG, 139% to 400% of FPG, and more than 400% of FPG); Asians, and Latinx[4] and white Californians; and people living in both urban and rural areas of the state (see Table 2, page 4). Comparing demographic subgroups against the statewide average found that most had rates that were not significantly different from California's 2018 rate, except for Black people, whose rate of 22% was significantly lower, and people with individual-market coverage, whose rate of 44% was significantly higher.

For the overall population of California (with ESI and individual-market coverage), 31% of people reported a deductible of more than $2,000 in 2018, which was roughly double the rate of 16% in 2013 — a statistically significant difference.

Table 2. Californians with Private Insurance Reporting Deductibles over $2,000, 2013 vs. 2018

	RATES		DIFFERENCES IN RATES	
	2013	2018	2013–18	2018 Subgroup vs. Overall
OVERALL	**16%**	**31%**	**15 pp***	**—**
Private Coverage Type				
Individual Market	49%	44%	–5 pp	13 pp†
Employer–Sponsored Insurance	12%	32%	20 pp*	0 pp
Income by Federal Poverty Guidelines				
0%–138%	15%	27%	12 pp*	–4 pp
139%–249%	22%	31%	9 pp*	0 pp
250%–399%	19%	33%	14 pp*	2 pp
400%+	14%	32%	18 pp*	1 pp
Race and Ethnicity				
Asian	15%	37%	22 pp*	6 pp
White	17%	32%	15 pp*	1 pp
Latinx	17%	30%	13 pp*	–1 pp
Black	15%	22%	7 pp	–11 pp†
Other/Multiple Races	20%	28%	8 pp	–3 pp
Native American	N/A	N/A	N/A	N/A
Geography				
Rural	20%	33%	13 pp*	2 pp
Urban	16%	31%	15 pp*	0 pp

*Statistically significant difference between 2013 and 2018 at 95% level.

†Statistically significant difference from overall rate at 95% level.

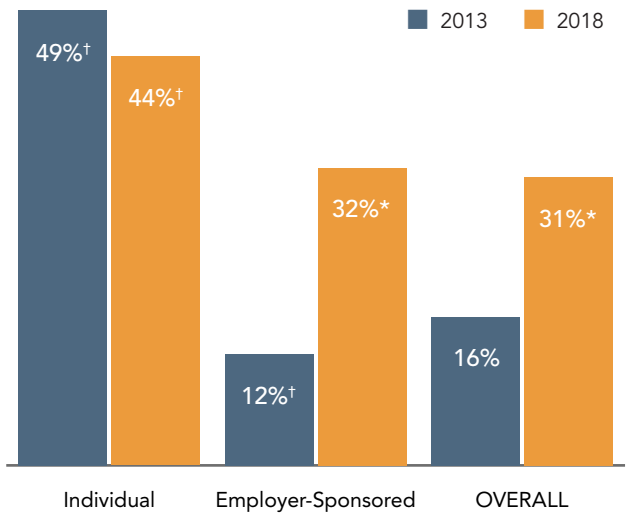
Notes: *Statistical significance* is a mathematical test of whether differences are real or the result of random chance. A confidence level of 95% means that researchers are 95% confident that the results were not due to random chance. CHIS uses *Hispanic*, *African American*, and *American Indian / Alaskan Native*. Percentage points noted as *pp*. *N/A* indicates that the sample size was not big enough to conduct an analysis.

Source: SHADAC analysis of California Health Interview Survey.

Rate of Large Deductibles More Than Doubled for Californians with ESI

Among people with ESI and individual-market coverage, there were statistically significant increases between 2013 and 2018 in the percentage of people with ESI reporting deductibles of more than $2,000, but no statistically significant changes for people with individual-market coverage (Figure 1). That increase in ESI deductibles is consistent with other research conducted by State Health Access Data Assistance Center (SHADAC) using federal survey data, which has found statistically significant increases since 2013 in both California and the US for rates of workers with high-deductible ESI plans.[5] Unsurprisingly, even with the statistically significant increases found among Californians with ESI, those with individual-market coverage still had higher rates of deductibles of $2,000 or more. In 2018, 44% of people with individual-market coverage had deductibles of $2,000 or more, but only 32% with ESI did.[6] That is because 49% of Californians with individual-market coverage already reported deductibles of more than $2,000 in 2013, a rate that was approximately four times the 12% among those with ESI.

Figure 1. Californians with Private Insurance with Deductibles Over $2,000, by Coverage Type, 2013 vs. 2018



*Statistically significant difference from 2013 at 95% level.

†Statistically significant difference from overall rate at 95% level.

Source: SHADAC analysis of California Health Interview Survey.

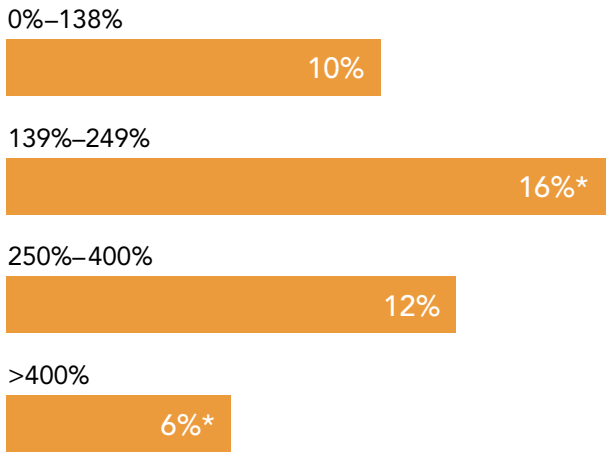
Trouble Paying Medical Bills

Another important measure for affordability of health care is whether people have trouble paying medical bills, which can occur for people without health insurance and even for those with health insurance, particularly when plans leave enrollees responsible for substantial portions of their health care bills. For this measure, data was analyzed from the CHIS on people who reported that they have ever experienced difficulty paying medical bills.

One in 10 Californians Report Trouble Paying Medical Bills

In 2018, 10% of Californians reported having trouble paying medical bills, although that varied across population subgroups. By income, 16% of people with incomes from 139% to 249% of FPG reported trouble paying medical bills, which was significantly higher than the statewide average (Figure 2).

Figure 2. Californians Reporting Trouble Paying Medical Bills, by Income Level, 2018



*Statistically significant difference from overall rate at 95% level.

Source: SHADAC analysis of California Health Interview Survey.

Unsurprisingly, people with the highest incomes (above 400% FPG) reported the lowest rate of trouble paying medical bills (6%), which was significantly lower than the statewide average. Among Californians with incomes 250% to 400% of FPG, 12% reported trouble paying medical bills, which was not significantly different than the statewide average. However, 16% of people with incomes from 139% to 249% reported trouble paying medical bills, which was significantly higher than the statewide average. In contrast, only 10% of Californians with incomes up to 138% of FPG reported trouble paying medical bills — the same rate as the statewide average. The fact that low-income Californians didn't report higher rates of trouble paying medical bills could be because many of them are eligible for expanded Medi-Cal under the ACA, which generally requires minimal or no cost sharing for covered health care services.

By coverage type, the uninsured and those with only Medicare coverage each reported trouble paying medical bills at rates significantly higher than the state average (14% and 15%, respectively). Although it may appear counterintuitive that 10% of Californians with incomes low enough to qualify for expanded Medi-Cal report trouble paying medical bills while 15% with current Medi-Cal coverage report trouble, there are multiple potential explanations for that difference. For example, because the CHIS asks whether people have ever had trouble paying medical bills, it's possible that eligible Californians who choose to enroll in Medi-Cal have had greater troubles paying medical bills before enrolling in the program, compared to people whose incomes make them eligible for Medi-Cal coverage but don't opt to enroll. Of people with other types of coverage, those with Medicare plus additional insurance (e.g., supplemental plans) reported significantly lower rates of trouble paying medical bills, at 4%. People with remaining coverage types — including Medicare-Medi-Cal dual-eligible enrollees, and those with Medi-Cal, ESI, and individual-market insurance — reported rates of trouble paying medical bills that weren't significantly different from the average rate of 10%.

By race and ethnicity, Asians reported trouble paying medical bills at a rate significantly different than the average, at 5%, as did those who reported being multiracial (20%) (see Table A1, page 10). Neither people in urban nor rural areas of the state reported rates of trouble paying medical bills that were significantly different than the average.

Financial Consequences of Medical Bills

The final measures examined two potential effects of trouble paying medical bills: first, use of credit card debt to finance medical bills, and second, difficulties affording basic needs, such as food and housing, due to medical bills. These two CHIS measures were only asked of the 10% of people who reported trouble paying medical bills, rather than all of Californians.

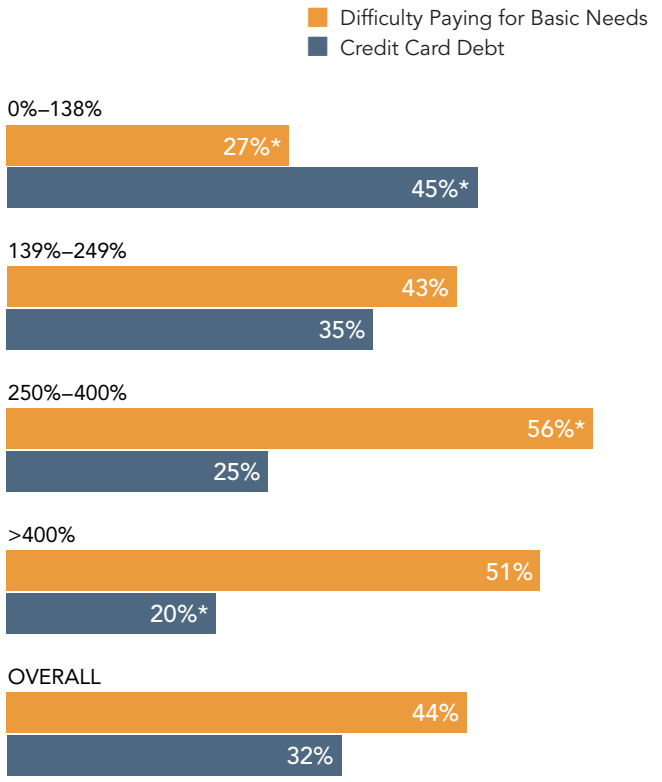
Financing of Medical Bills Through Credit Card Debt Higher Among Individual-Market Beneficiaries Who Report Trouble Paying Medical Bills

Statewide, 44% of those who reported trouble paying medical bills said they used credit card debt to pay their medical bills. Furthermore, 35% of people reporting use of credit cards to finance medical bills reported incurring debt of $4,000 or more.

Use of credit card debt to pay for medical bills varied across subgroups. By coverage type, 60% of people with individual-market coverage who reported trouble paying medical bills said they used credit card debt. That may reflect higher cost sharing in individual-market plans. For example, as discussed earlier, significantly higher rates of people with individual-market coverage report deductibles of more than $2,000, and other research has shown that Californians with individual-market coverage spend more on health care than the overall state average.[7]

By income, people with low incomes of up to 138% FPG were significantly less likely (27%), while those with incomes 250% to 400% were significantly more likely (56%) (see Figure 3) than the statewide average to use credit card debt to pay for medical bills. By race and ethnicity, only 34% of Latinx Californians who reported trouble paying medical bills reported use of credit card debt, which was significantly lower than average, while 51% of white Californians reported use of credit card debt, which was significantly higher.

Figure 3. Trouble Paying Basic Necessities and Use of Credit Card Debt to Pay Medical Bills, Among Those Reporting Trouble Paying Medical Bills, by Income Level, 2018



*Statistically significant difference from overall rate at 95% level.

Source: SHADAC analysis of California Health Interview Survey.

Difficulty Affording Basic Necessities Higher Among Medi-Cal Enrollees with Low Incomes

Thirty-two percent of those who reported trouble paying medical bills said those bills caused them difficulties affording basic necessities, such as housing and food.

By coverage type, only people with Medi-Cal coverage reported rates of difficulty affording basic necessities that were significantly higher than the statewide average (45%), while people with ESI and Medicare plus other coverage reported rates that were significantly lower than average (23% and 21%, respectively). By income, only those with incomes up to 138% of FPG reported rates of difficulty affording basic necessities that were higher than average (45%), while those with incomes over 400% FPG reported rates significantly lower than average (20%). By race and ethnicity, 40% of Latinx Californians reported difficulty affording basic necessities, which was significantly higher than the average rate.

When considered together, these two measures — use of credit card debt to pay medical bills and trouble affording basic necessities due to medical bills — suggest that these two consequences of unaffordable medical bills are inversely related. For example, Latinx Californians and people with low incomes are less likely to report using credit cards to pay for medical bills but more likely to report trouble affording basic necessities. That relationship could be due, at least in part, to access to credit, causing people without the backstop of a credit card to face trouble affording basic necessities.

Conclusion

Overall, this analysis found that affordability of health insurance and health care continued to pose challenges for Californians in 2018. Although California's robust implementation of the ACA has resulted in more people being covered than ever before, increasing rates of deductibles over $2,000 shows that insurers are increasingly pushing more of those costs to enrollees themselves. People with individual-market coverage already were experiencing relatively high rates of deductibles over $2,000 before the ACA. Now even Californians with ESI have become responsible for a larger share of their initial health care costs, with a doubling in the rate of deductibles over $2,000 for people with ESI since 2013 — a finding consistent with other research showing growth of high-deductible ESI plans in California and the US.[8]

Also, Californians continue to experience trouble paying medical bills and follow-on financial consequences — even among those with health insurance. In 2018, 1 in 10 Californians reported that they have experienced trouble paying medical bills. The subsequent financial consequences that some of these Californians reported may be cause for additional concern. Of people reporting trouble paying medical bills, 44% said they relied on credit card debt to pay those bills — and roughly one-third of those respondents reported credit card debt of $4,000 or more. And 32% of Californians who reported trouble paying medical bills said those bills caused them difficulties paying for basic necessities, such as food and housing. The pattern in the data may suggest that people with reduced access to credit, such as people with low incomes, are more likely to face these difficulties affording basic necessities.

Long-term trends of increasing health care costs and health plan design (e.g., high-deductible plans) may continue to place increasing affordability pressures on Californians. Additionally, recent policy, economic, and public health developments could affect the affordability of health care and insurance in various ways. For instance, California's creation of new state-funded subsidies makes individual-market coverage more affordable for some people purchasing through Covered California, the state's ACA marketplace. And California's creation of a tax penalty for failure to have health insurance, adopted in response to Congress's 2017 decision to eliminate the national individual mandate penalty, also could help keep coverage through Covered California more affordable — expanding the number of healthy people purchasing insurance through Covered California could contribute to lower premiums. In contrast, health care costs associated with the COVID-19 pandemic and related economic consequences of the crisis could make health coverage less affordable. For instance, the economic downturn may make it harder for people to get coverage they can afford, and health care costs associated with the pandemic, including the costs of deferred care, could result in higher premiums in future years. It will be important to continue monitoring these measures of health care and insurance affordability in coming years to inform future policy in this area.

About the Authors

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About the Foundation

The California Health Care Foundation is dedicated to advancing meaningful, measurable improvements in the way the health care delivery system provides care to the people of California, particularly those with low incomes and those whose needs are not well served by the status quo. We work to ensure that people have access to the care they need, when they need it, at a price they can afford.

CHCF informs policymakers and industry leaders, invests in ideas and innovations, and connects with changemakers to create a more responsive, patient-centered health care system.

For more information, visit www.chcf.org.

Endnotes

1. *Uninsurance Rates for California in 2013 and 2014* (PDF), State Health Access Data Assistance Center (SHADAC), n.d.
2. Eran Ben-Porath et al., *Health Care Priorities and Experiences of California Residents: Findings from the California Health Policy Survey* (PDF), California Health Care Foundation (CHCF), February 2020.
3. Due to rounding, individual estimates may not add up to totals.
4. CHIS uses *Hispanics*.
5. Elizabeth Lukanen, Robert Hest, Brett Fried. *State-Level Trends in Employer-Sponsored Health Insurance (ESI), 2013–2017* (PDF) (California), SHADAC, 2017. See also US analysis. In the referenced research, "high deductibles" are defined as $1,300 for individual or $2,600 for family-coverage ESI.
6. Notably, for silver and higher metal tier plans offered through Covered California, most outpatient care is not subject to the deductible. See page 6 of *Health Insurance Companies and Plan Rates for 2020* (PDF), Covered California, October 2019.
7. Lacey Hartman, *Affordability on California's Individual Market Under the ACA*, CHCF, May 2019.
8. *State-Level Trends*.

Appendix A. Supplemental Data Tables

Table A1. Californians Reporting Trouble Paying Medical Bills, 2018

	RATE	SUBGROUP VS. OVERALL
OVERALL	**10%**	—
Coverage Type		
▶ Uninsured	14%	4 pp*
Private		
▶ Individual Market	11%	1 pp
▶ Employer-Sponsored Insurance	10%	0 pp
Public		
▶ Medicare Only	15%	5 pp*
▶ Medi-Cal	10%	0 pp
▶ Medicare and Medi-Cal	8%	–2 pp
▶ Medicare and Other	4%	–6 pp*
▶ Other Public Coverage	N/A	N/A
Income by Federal Poverty Guidelines		
▶ 0%–138%	10%	0 pp
▶ 139%–249%	16%	6 pp*
▶ 250%–399%	12%	2 pp
▶ 400%+	6%	–4 pp*
Race and Ethnicity		
▶ Other/Multiple Races	20%	10 pp*
▶ Latinx	11%	1 pp
▶ White	10%	0 pp
▶ Black	9%	1 pp
▶ Asian	5%	–5 pp*
▶ Native American	N/A	N/A
Geography		
▶ Rural	12%	2 pp
▶ Urban	9%	1 pp

*Statistically significant difference between subgroup and overall at 95% level. Statistical significance is a mathematical test of whether differences are real or the result of random chance. A confidence level of 95% means that researchers are 95% confident that the results were not due to random chance.

Notes: CHIS uses *Hispanic, African American,* and *American Indian / Alaskan Native.* Percentage points noted as *pp. N/A* indicates that the sample size was not big enough to conduct an analysis.

Source: SHADAC analysis of "California Health Interview Survey."

Table A2. Californians Reporting Use of Credit Card Debt to Pay Medical Bills, Among Those Who Report Trouble Paying Medical Bills, 2018

	RATE	SUBGROUP VS. OVERALL
OVERALL	**44%**	—
Coverage Type		
▶ Uninsured	30%	–14 pp
Private		
▶ Individual Market	60%	16 pp*
▶ Employer–Sponsored Insurance	50%	6 pp
Public		
▶ Medicare Only	59%	15 pp
▶ Medicare and Other	41%	–3 pp
▶ Medi-Cal	36%	–8 pp
▶ Medicare and Medi-Cal	28%	–16 pp*
▶ Other Public Coverage	N/A	N/A
Income by Federal Poverty Guidelines		
▶ 0%–138%	27%	–17 pp*
▶ 139%–249%	43%	1 pp
▶ 250%–399%	56%	12 pp*
▶ 400%+	51%	7 pp
Race and Ethnicity		
▶ Other/Multiple Races	64%	20 pp
▶ White	51%	8 pp*
▶ Black	50%	6 pp
▶ Asian	38%	–6 pp
▶ Latinx	34%	–10 pp*
▶ Native American	N/A	N/A
Geography		
▶ Urban	44%	0 pp
▶ Rural	42%	–2 pp

*Statistically significant difference between subgroup and overall at 95% level. Statistical significance is a mathematical test of whether differences are real or the result of random chance. A confidence level of 95% means that researchers are 95% confident that the results were not due to random chance.

Notes: CHIS uses *Hispanic*, *African American*, and *American Indian / Alaskan Native*. Percentage points noted as *pp*. *N/A* indicates that the sample size was not big enough to conduct an analysis.

Source: SHADAC analysis of "California Health Interview Survey."

Table A3. Californians Reporting Difficulty Affording Basic Necessities Due to Medical Bills, Those Who Report Trouble Paying Medical Bills, 2018

	RATE	SUBGROUP VS. OVERALL
OVERALL	**32%**	—
Coverage Type		
▶ Uninsured	45%	13 pp
Private		
▶ Employer–Sponsored Insurance	23%	–9 pp*
▶ Individual Market	N/A	N/A
Public		
▶ Medi-Cal	45%	13 pp*
▶ Medicare and Medi-Cal	42%	10 pp
▶ Medicare and Other	21%	–11 pp*
▶ Medicare Only	N/A	N/A
▶ Other Public Coverage	N/A	N/A
Income by Federal Poverty Guidelines		
▶ 0%–138%	45%	13 pp*
▶ 139%–249%	35%	3 pp
▶ 250%–399%	25%	–7 pp
▶ 400%+	20%	–12 pp*
Race and Ethnicity		
▶ Latinx	40%	8 pp*
▶ Black	26%	–6 pp
▶ White	26%	–6 pp
▶ Asian	N/A	N/A
▶ Other/Multiple Races	N/A	N/A
▶ Native American	N/A	N/A
Geography		
▶ Urban	32%	0 pp
▶ Rural	31%	–1 pp

*Statistically significant difference between subgroup and overall at 95% level. Statistical significance is a mathematical test of whether differences are real or the result of random chance. A confidence level of 95% means that researchers are 95% confident that the results were not due to random chance.

Notes: CHIS uses *Hispanic, African American,* and *American Indian / Alaskan Native.* Percentage points noted as *pp. N/A* indicates that the sample size was not big enough to conduct an analysis.

Source: SHADAC analysis of "California Health Interview Survey."