

MEDI-CAL STATISTICAL REPORT

JUNE 2014

Medi-Cal's Nonelderly Adults:

The Medi-Cal Population Before the Implementation of the Affordable Care Act

Introduction

California was one of many states that voluntarily expanded Medicaid under the Affordable Care Act (ACA) through the extension of benefits to previously unqualified populations. Since 2010, California anticipated ACA implementation by developing several transitional programs, most notably the California "Bridge to Reform" Waiver, which allowed counties to begin enrolling ACA-eligible adult populations in advance of full implementation. By January 2012, Medi-Cal had enrolled over 350 thousand nonelderly adults in Low Income Health Programs (LIHP) created for that purpose.¹ Evaluating the effects of this transition and the full implementation of the ACA on California's Medicaid program, Medi-Cal, requires researchers and stakeholders to possess a clear understanding of the Medi-Cal population before the expansion.

To address this informational need, the Research and Analytic Studies Division (RASD) has created the following report on the socio-demographic, regional, and health characteristics of the 2011-12 nonelderly adult Medi-Cal population. These statistics provide stakeholders with a highly textured point-in-time depiction of the Medi-Cal population, which may serve as a comparative baseline as ACA transition data becomes available.

Key Findings:

- Over half (52.0%) of adults in Medi-Cal had incomes below 100% FPL, compared to 28.5% of adults without insurance and 5.3% of privately insured adults.
- The ACA grants Medi-Cal coverage to adults with incomes at or below 138% FPL. In 2012, 67.8% of Medi-Cal enrollees, 44.6% of the uninsured, and 9.6% of the privately insured had incomes at or below 138% FPL.
- Adults with private insurance were more than twice as likely (48.3%) to have a college degree than adults with no insurance (17.3%) and more than five times more likely than adults with Medi-Cal (8.5%).
- Adults in Medi-Cal were almost twice as likely to experience food insecurity (42.2%) than uninsured (28.7%) and privately insured (5.8%) adults.
- Adults with private insurance were less likely to smoke (6.7%) when compared to adults in Medi-Cal (14.2%) and those without insurance (13.2%).
- Adults in Medi-Cal were less likely (61.4%) to find affordable fruits and vegetables in their neighborhood than adults with private insurance (81.0%) or no insurance (69.4%).
- Daily soda consumption was more than twice as common among adults with Medi-Cal (20.5%) than the privately insured (8.8%).
- Adults in Medi-Cal were more than twice as likely to have serious psychological distress as the privately insured (6.6%) and 1.5 times more likely than the uninsured (9.3%).
- Disability was more common among adults in Medi-Cal (44.8%) than adults without insurance (27.4%) and those with private insurance (19.3%).
- A greater proportion of adult Medi-Cal women under 45 were pregnant (7.4%) than women under 45 with private insurance (3.2%), and women under 45 without insurance (1.0%).
- Adults enrolled in Medi-Cal were three times more likely (35.2%) than adults with private insurance (10.7%) to have fair or poor health.

To create a nuanced picture of the 2011-12 Medi-Cal population, RASD combined Department of Health Care Services (DHCS) administrative data and data derived from the California Health Interview Survey (CHIS). As a survey, CHIS provides information on socio-demographic determinants of health and health behaviors not available in administrative data. In turn, Medi-Cal administrative data balances the limitations of a telephone survey such as CHIS; while CHIS provides data from a sample of respondents weighted to represent the entire state, Medi-Cal administrative data includes a record for each Medi-Cal beneficiary.

This report is the first in a series that RASD is preparing on the Medi-Cal population before ACA implementation. This report will focus on the population that stakeholders believe will expand most dramatically with ACA implementation—nonelderly adults age 18 to 64. Corresponding reports on the elderly and child populations, as well as related statistical publications, will be available on the RASD [website](#) when completed.

Data Sources

RASD used two complementary data sources to create this report: DHCS administrative Medi-Cal data and CHIS survey data. Statewide statistics match those reported on the California Department of Finance [website](#). [Appendix A](#), Data Sources and Methods, contains a detailed technical discussion of the data and methodology used to produce the statistics in this report.

CHIS

CHIS is an independent, population-based telephone survey that represents California's non-institutionalized population living in households. CHIS covers a wide range of topics focused on the health and health care needs of California's diverse population. Although CHIS addresses recognized negative health behaviors, it also captures factors more subtly related to health, such as soda consumption, the availability of affordable fruits and vegetables, and neighborhood cohesion factors. Because this level of detail is not available through administrative data, CHIS is a valuable resource for Medi-Cal stakeholders. Further, the addition of CHIS data allowed RASD to present the Medi-Cal population alongside privately insured and uninsured residents of the state, giving context to these unique statistics.

CHIS is a continuous survey that takes two years to complete a data cycle. During 2011 and 2012, CHIS completed 42,935 adult interviews. Of these, 27,370 interviewees were nonelderly adults (ages 18-64). This report includes data on the 4,047 Medi-Cal enrollees, 18,125 privately insured, and 5,198 uninsured nonelderly adults interviewed during the study period. For the purpose of this analysis, RASD excluded adults enrolled in only Medicare from the study population and considered adults with employee-based insurance as having private insurance.

DHCS Administrative Data

RASD drew enrollment eligibility data from Medi-Cal Eligibility Data Systems (MEDS) January 2012, reflecting a 12-month reporting lag, for 3,048,350 non-elderly adults. RASD considers a specific month's

eligibility count finalized 12 months after the month's end; therefore, RASD utilized a 12-month reporting lag to ensure the data is as complete as possible.

RASD confined the study of Medi-Cal beneficiaries to “certified eligibles,” individuals who received a valid eligibility determination and were enrolled during January 2012.² The certified eligible classification excludes beneficiaries who were qualified for Medi-Cal but not enrolled during the period,³ as well as beneficiaries who were required to meet a monthly Share of Cost (SOC) obligation as a condition of receiving Medi-Cal-covered services, but did not meet that obligation in January 2012.

Limitations

The CHIS survey presents estimated characteristics for the entire California population produced using a representative sample of interviewees from the state of California. As such, readers should review this report with an awareness of sampling error. Sampling error is the deviation between the ‘true’ value of the characteristics for a population and the estimate of the characteristics produced from a sample of the population. Charts derived from CHIS data include individual confidence intervals to provide readers with an indication of the reliability in the estimates.

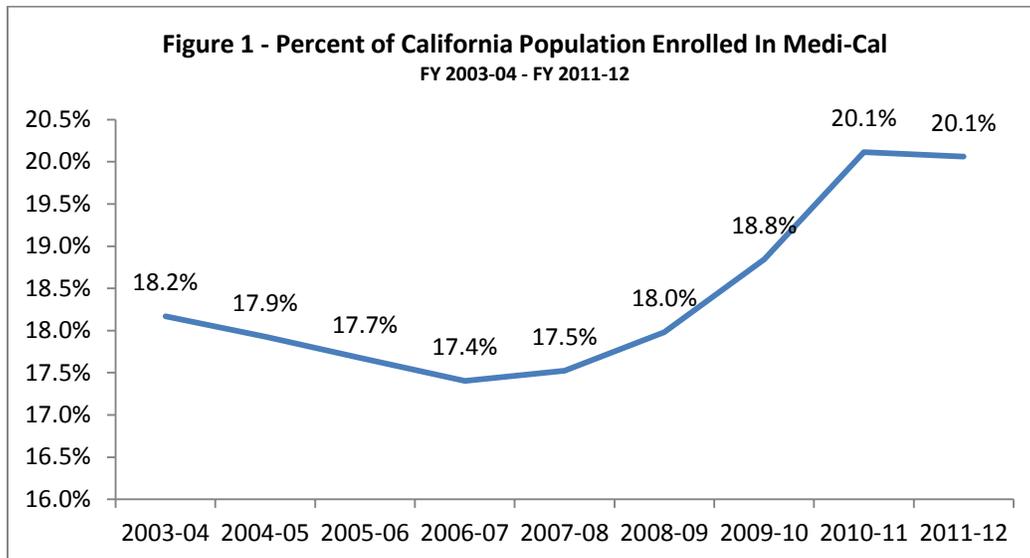
Medi-Cal is a safety-net program intended to provide health care to individuals who might otherwise struggle to secure affordable health insurance. Many Medi-Cal beneficiaries qualify based on their income relative to the federal poverty level (FPL), coupled with their assets, deprivation (deprivation represents the absence of one parent or the underemployment or unemployment of the principal wage earner in the family with children), disability, and health needs not addressed through other means. Readers should remain mindful of Medi-Cal eligibility guidelines when drawing conclusions about differences between the Medi-Cal, privately insured, and uninsured populations. RASD advises readers to interpret other economic indicators in this report (unemployment, educational attainment, home ownership, etc.), when comparing groups, with similar consideration for Medi-Cal’s program goals and eligibility guidelines.

How to Read this Report

This report contains a general discussion and data analysis on 33 topics related to the health of the California population in 2011-12. As noted above, RASD used two complementary data sources to create this report: DHCS administrative Medi-Cal data and CHIS survey data. Sub-headers on each “Findings” page state which of these two data sources RASD used to produce the statistics related to that topic area. RASD advises readers to note the data source for each topic and remain mindful of the limitations specific to that data source when reviewing the report.

Background:

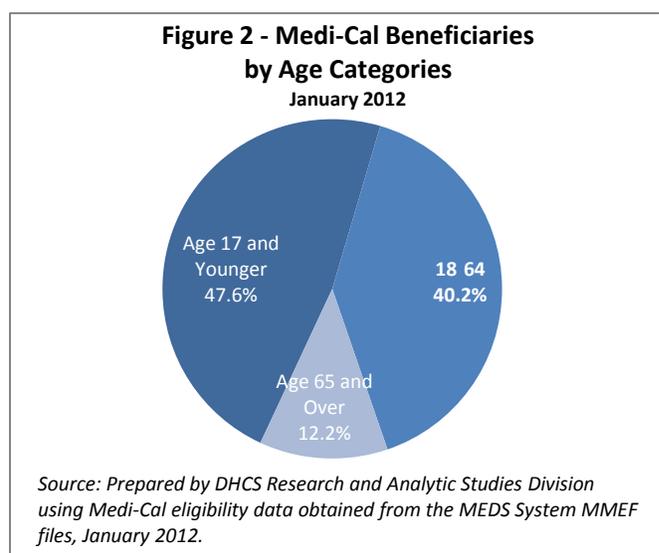
Medi-Cal is the joint state-federal program that provides low- and no-cost health care to low-income residents of California. While Medi-Cal eligibility is generally based on income relative to the FPL,⁴ the program also provides coverage to individuals considered blind or disabled under the Social Security Administration, individuals with qualifying health conditions (such as breast cancer or tuberculosis), and Medicare enrollees who meet specific income requirements. With annual spending of over \$55 billion in 2011, Medi-Cal is an essential financier of health care in California and provides care to a substantial percentage of the population.^{5,6}



In January 2012, over 7 million Californians participated in Medi-Cal, accounting for 20.1% of the state's population. This value represents a leveling off of the previous trend; from 2007-08 to 2010-11 Medi-Cal provided services to a steadily increasing percentage of California's population, which was primarily driven by the nation's economic recession. Although there was no significant increase from 2010-11 to 2011-12, stakeholders predict that the percentage of Californians enrolled in Medi-Cal will continue to increase under the ACA.

Study Population:

This analysis will focus on Medi-Cal beneficiaries ages 18 to 64, enrolled during the 2011-12 period. As of January 2012, this cohort accounted for over 3 million beneficiaries and 40.2% of the Medi-Cal population. Beneficiaries ages 17 and younger made up 47.6% of the Medi-Cal population in January 2012, and beneficiaries ages 65 and older accounted for 12.2%.

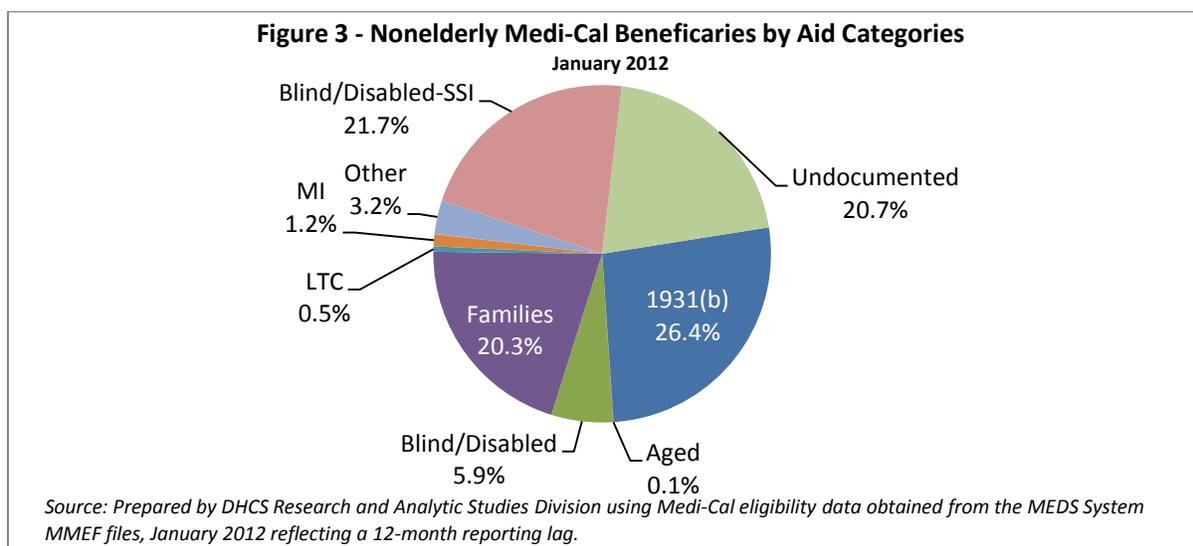


Eligibility Pathway of Study Population

In Medi-Cal, an eligibility pathway represents the means by which a beneficiary qualified for Medi-Cal coverage. For analysis, eligibility pathways can be grouped into and presented as “aid categories.” In addition to representing the way a beneficiary qualified for Medi-Cal, aid categories reveal the scope of services available to that individual..

For the purpose of this analysis, RASD grouped Medi-Cal’s nonelderly adult population into nine broad categories: Families, 1931(b)-Non-CalWORKS, Blind/Disabled, Blind/Disabled receiving cash assistance under the Supplemental Security Income (SSI) program, Undocumented, Aged, Medically Indigent (MI), Long-Term Care (LTC), and All Other. The Families aid group includes parents/caretaker relatives in low income families with dependent children. The 1931(b)-non-CalWORKs aid category is a large subset of the Families grouping that covers children and caretaker relatives who were eligible for Medi-Cal under the former Aid to Families with Dependent Children (AFDC) program. The Medically Indigent (MI) aid category covers adults with no other Medi-Cal linkage who meet one the following requirements: resides in a skilled nursing facility; have resided in the U.S. for less than eight months on a refugee status; or are pregnant and do not qualify under any other Medi-Cal program.⁷ The SSI aid category covers individuals who receive Medi-Cal as an automatic condition of their receiving SSI cash assistance. The Undocumented aid category covers beneficiaries without satisfactory immigration status (SIS). In general, beneficiaries qualified under an Undocumented aid category are only eligible for emergency or pregnancy-related services through Medi-Cal. Beneficiaries enrolled in the Blind/Disabled aid category qualify by meeting the SSI medical definition of disability. Beneficiaries enrolled in the Long-Term Care (LTC) aid category reside in a LTC facility and meet all other Medi-Cal income requirements. The All Other aid category is an aggregate of nonelderly adults eligible for Medi-Cal under an aid code not specifically listed.

In January 2012, beneficiaries enrolled in 1931(b)-Non-CalWORKs made up 26.4% of the nonelderly adult population, with beneficiaries enrolled in Families (20.3%), Blind/Disabled-SSI (21.7%), and Undocumented (20.7%) aid categories contributing the only other substantial percentages.

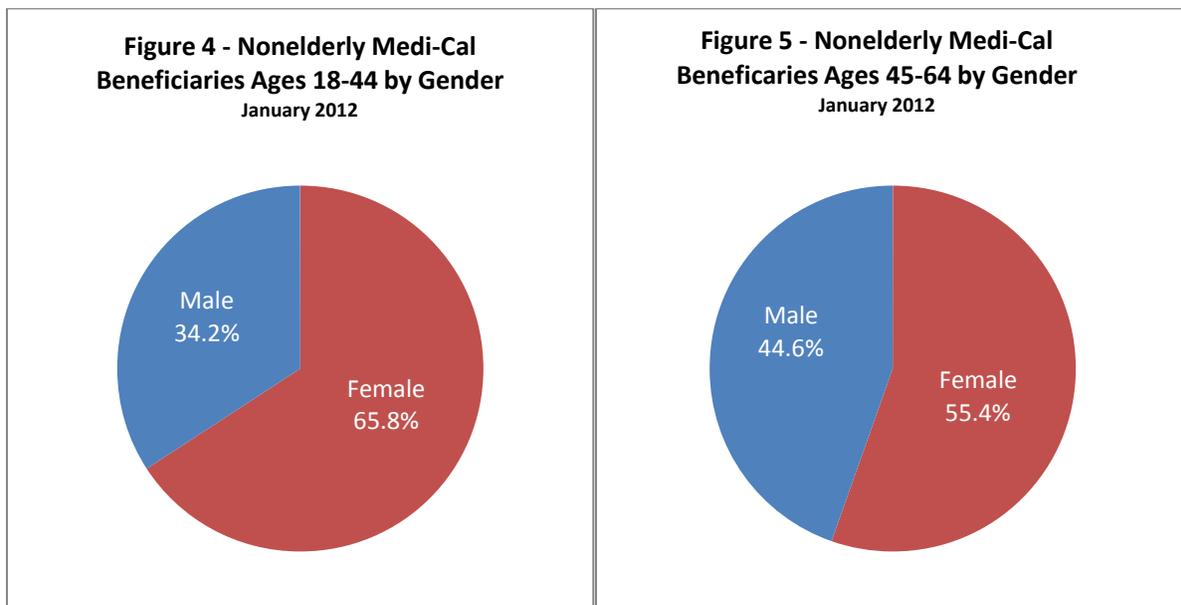


Findings: Age and Gender in Medi-Cal’s Nonelderly Adult Population

Derived from DHCS Administrative eligibility data.

Historically, young adults in the U.S. have had disproportionately low rates of insurance coverage and individuals ages 19 through 29 have long had the highest uninsured rate of any age group.⁸ Prior to the implementation of the ACA, employer-based insurance dropped dependents from private plans at age 19 or 22, depending on their status as full-time students. Most young people cited “cost” as the reason behind not purchasing insurance, due to frequently taking jobs that did not offer health benefits, or lacking permanent employment upon first entering the workforce.⁹ Older adults are more likely to have full-time employment with health benefits, contributing to the declining number of enrollees among the older age groups.

Women make up a large proportion of the Medi-Cal population, particularly during their reproductive years (ages 15 to 44). However, the proportion of women to men in Medi-Cal normalizes as the population ages out of reproductive age. In addition to receiving Medi-Cal coverage during pregnancy, women are more likely than men to be caregivers and receive Medi-Cal as a parent of an eligible child under Families aid codes.¹⁰



Source: Prepared by DHCS Research and Analytic Studies Division using Medi-Cal eligibility data obtained from the MEDS System MMEF files, January 2012 reflecting a 12-month reporting lag.

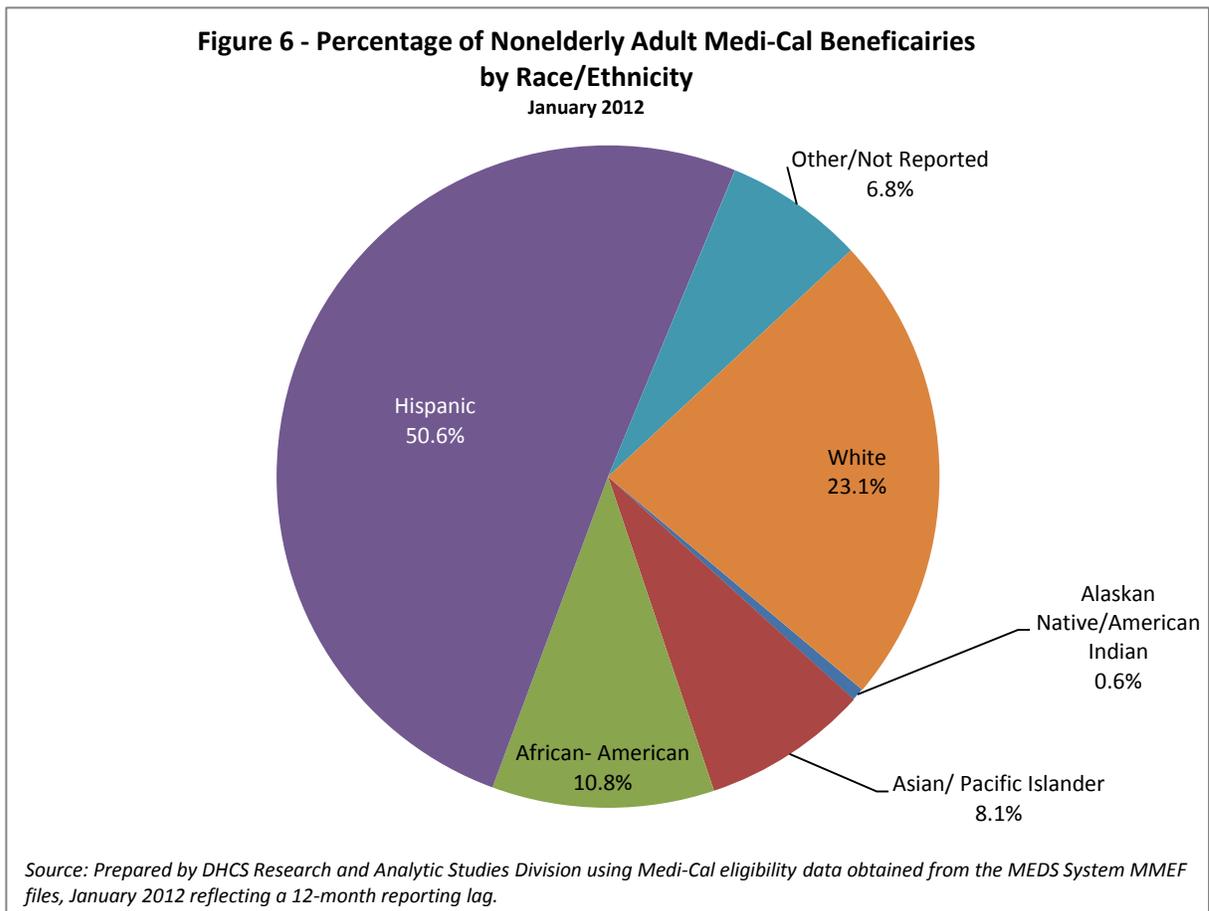
Findings: Race and Ethnicity in Medi-Cal’s Nonelderly Adult Population

Derived from DHCS Administrative eligibility data.

Differences in health outcomes for racial and ethnic minorities remain a persistent problem in health care. Racial and ethnic minorities are less likely to receive routine medical treatments, and experience a lower quality of health care.¹¹ In addition, the social, economic, and environmental disadvantages faced by some ethnic groups contribute to health disparities.¹²

Reduced access to health insurance and health care services exacerbate the difficulty in addressing variability in health outcomes for racial and ethnic minorities. Minorities are less likely to have employer-based insurance, which contributes to lower rates of insurance among minorities.¹³

Hispanics accounted for 50.6% of the Medi-Cal population. Non-Hispanic whites were the second largest group with 23.1%, followed by African-Americans (10.8%) and Asian/Pacific Islanders (8.1%). In contrast, whites accounted for the largest proportion of the overall California population (39.4%), and Hispanics accounted for 38.2%.¹⁴



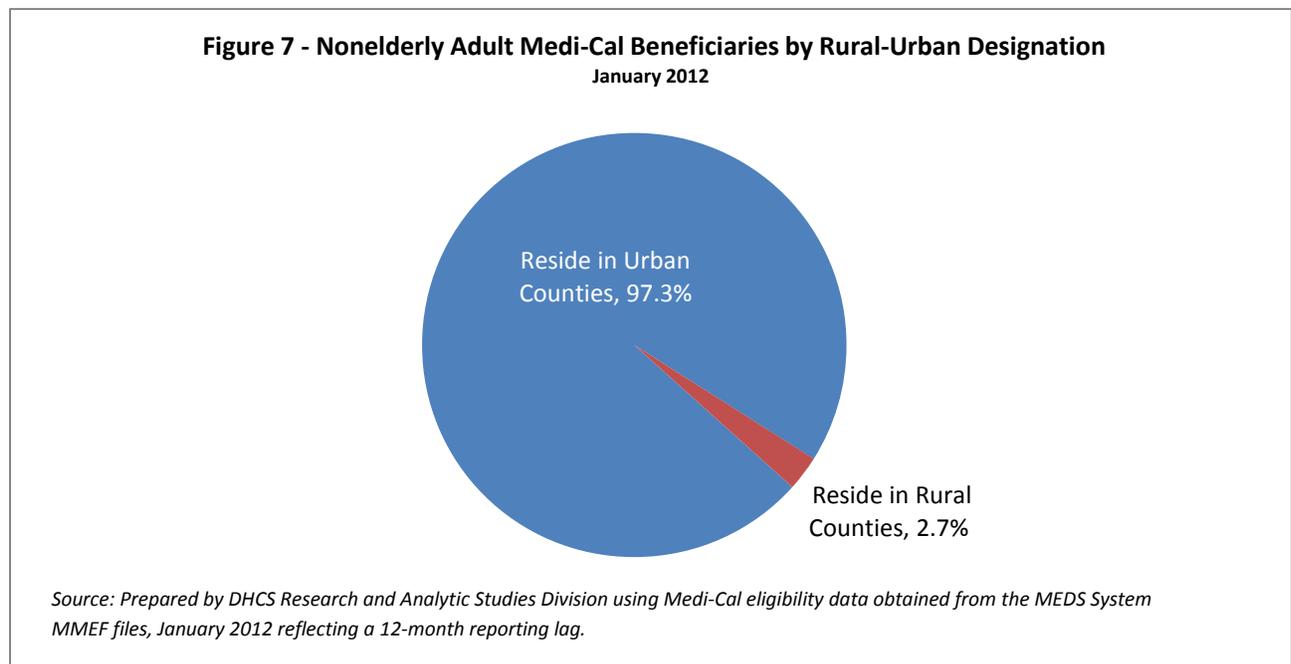
Findings: Regional Distribution in Medi-Cal’s Nonelderly Adult Population

Derived from DHCS Administrative eligibility data.

In 2012, 79% of the U.S. population lived in metropolitan areas.¹⁵ Where a community falls on the urban to rural spectrum influences its demographic, environmental, economic, and social characteristics. Urban counties have younger, more diverse populations and higher concentrations of poverty, whereas rural populations live further from health resources.¹⁶ Geographic distance, severe weather, lack of transportation, or challenging traveling conditions may restrict health care access. Emergency response times are also a serious concern for rural populations that tend to be older and have more chronic health conditions.¹⁷ Rural populations are more likely to have chronic diseases and mental health issues, have higher proportions of obesity, and higher rates of infant mortality.¹⁸ Rural residents are also less likely to have insurance coverage through Medicaid.¹⁹

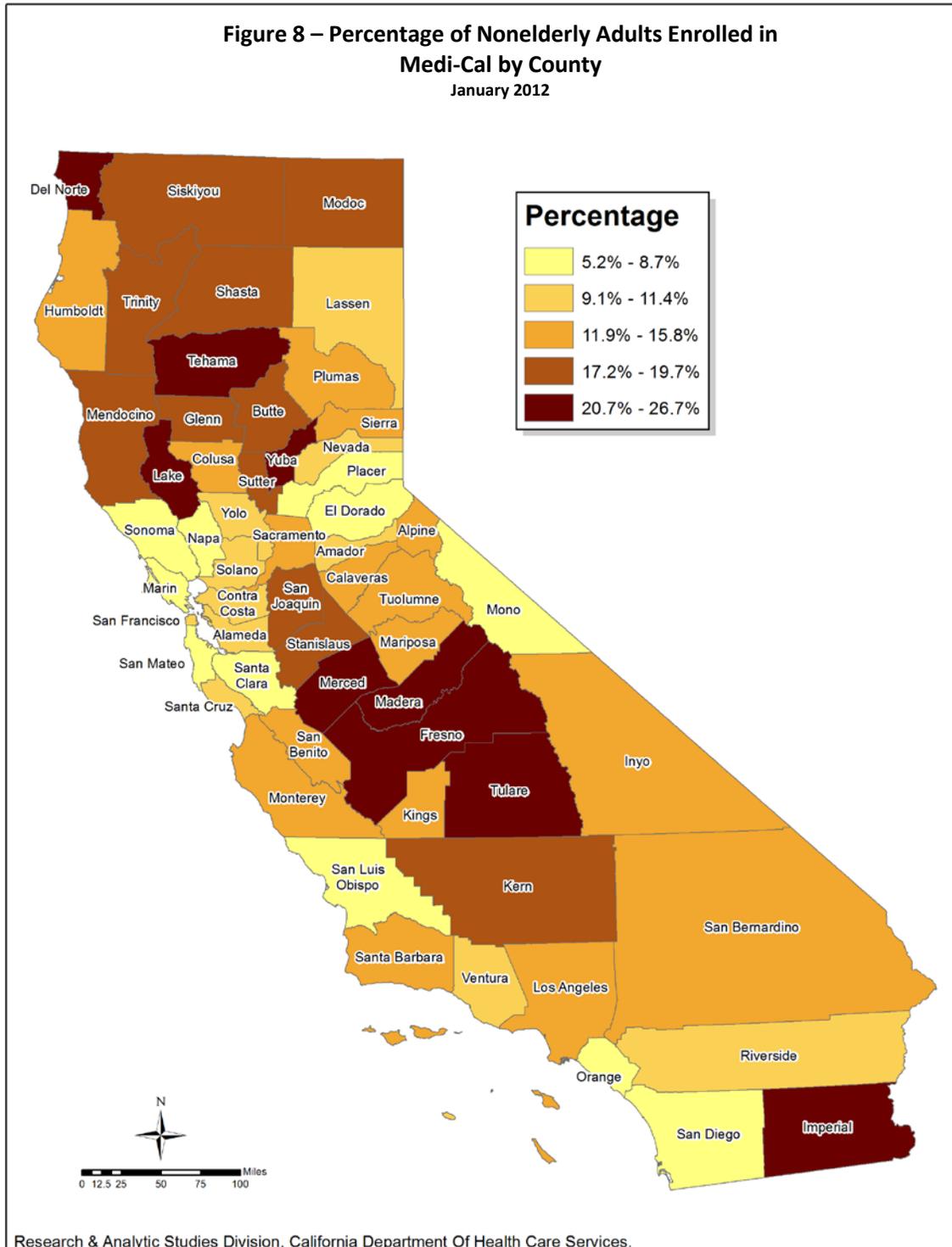
For this analysis, RASD defined an urban county as one in an established metropolitan region based on population size, degree of urbanization, and adjacency to a metropolitan area (see [Appendix A, Data Sources and Methods](#)). RASD classified counties outside or adjacent to metropolitan areas as rural. California’s population is highly urbanized. While California has 37 urban counties and 21 rural counties, 87% of the population lives in urban areas. This proportion reflects the population concentration inherent in the urban-rural analysis; rural counties have much smaller populations and thus account for a much smaller percent of the state’s population.

The majority of nonelderly Medi-Cal beneficiaries live in urban areas (97.3%). Only a very small proportion (2.7%) lives outside of urban areas.



Findings: Percentage of Nonelderly Adults Enrolled in Medi-Cal by County

Derived from DHCS Administrative eligibility data.



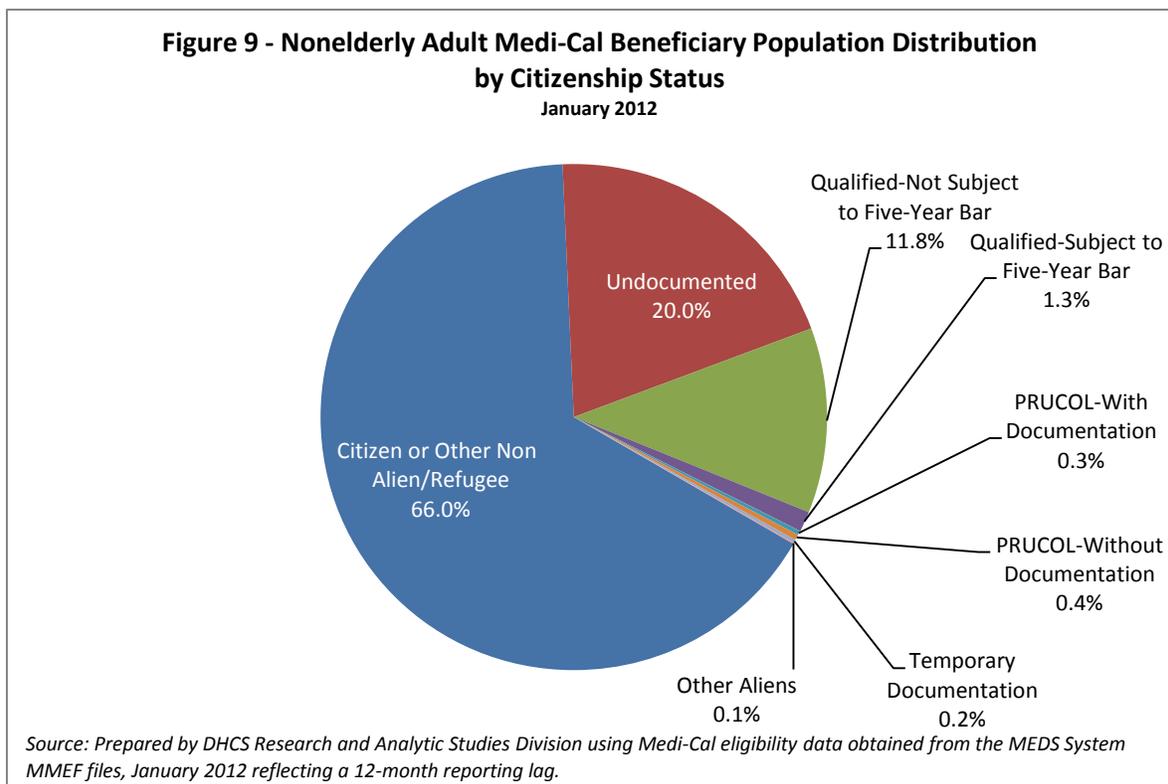
Findings: Citizenship Status in Medi-Cal’s Nonelderly Population

Derived from DHCS Administrative eligibility data.

Immigrants are a diverse, vulnerable, and growing part of the U.S. population. Generally, immigrants arrive in the U.S. healthier than their native-born counterparts, but tend to lose that advantage over time as they reside in the U.S. and adopt American lifestyle choices.^{20,21} Additionally, because immigrants tend to be marginalized, they are at increased risk for poor health outcomes. Immigrants have lower rates of health insurance, use less health care, and receive poor quality of care.²²

In general, undocumented immigrants, immigrants with Permanently Residing Under Color of Law (PRUCOL) status, and legal immigrants residing in the U.S. for less than 5 years are not eligible for full-scope Medicaid benefits under federal guidelines. California offers full-scope Medi-Cal coverage to legal immigrants, PRUCOL immigrants, and naturalized citizens provided that they meet all other Medi-Cal qualifications, regardless of the length of their residency.²³ Because the federal government only funds emergency and pregnancy-related services for the above populations, all other services are state-funded.²⁴ In California, undocumented immigrants are only eligible for emergency and pregnancy-related services through Medi-Cal.

Citizens and other non-alien or refugees accounted for 66.0% of the Medi-Cal population. The next largest group was beneficiaries without SIS (Undocumented), who made up 20.0% of Medi-Cal, followed by the Qualified – Not Subject to the Five-Year Bar group (11.8%) and Qualified – Subject to the Five-Year Bar (1.3%).

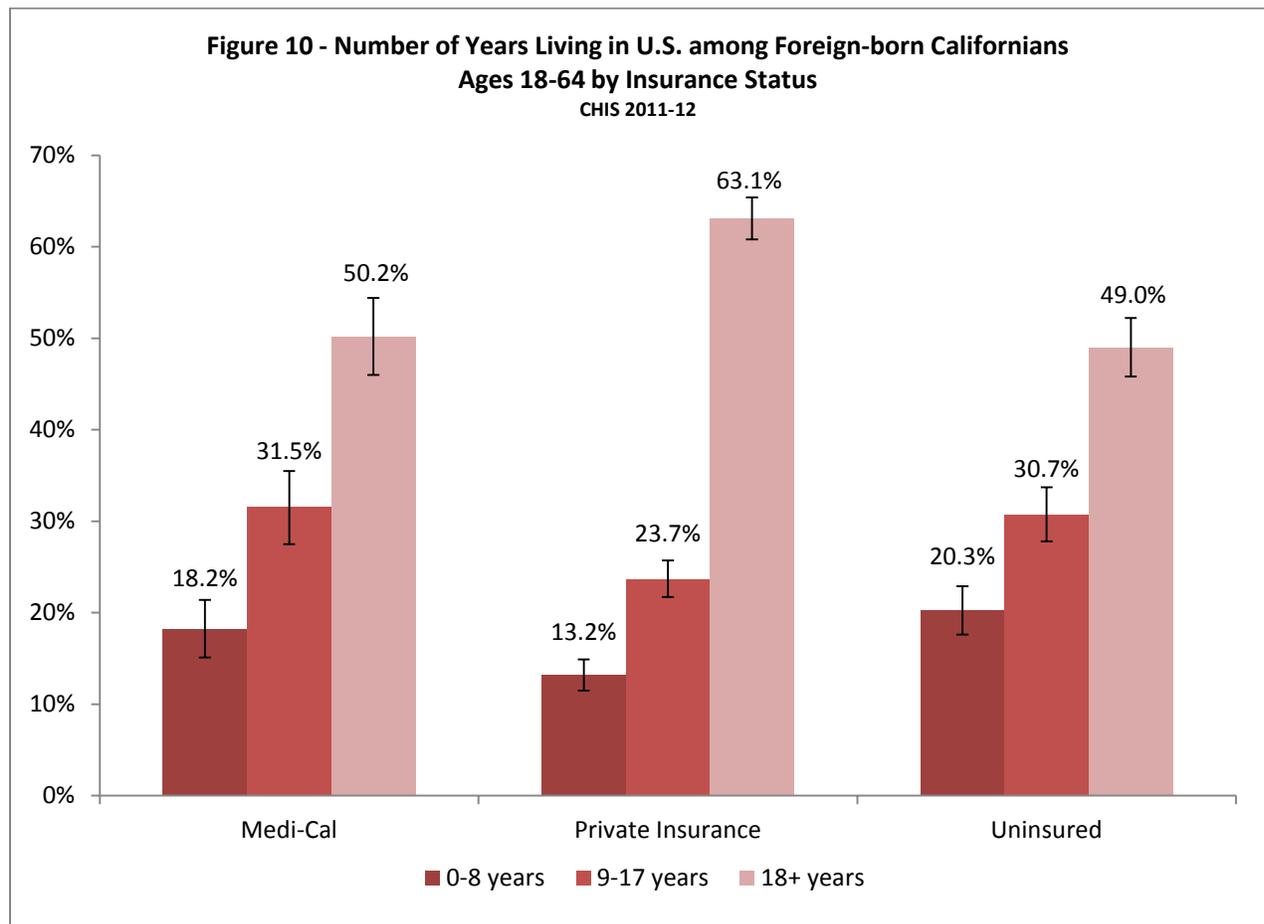


Findings: Number of Years in the U.S. in Medi-Cal’s Nonelderly Adult Population

CHIS Question: “About how many years have you lived in the United States?”

Upon coming to the U.S., immigrants are healthier than their American counterparts; however, this health advantage erodes over time.²⁵ Immigrants arrive in the U.S. with body mass index (BMI) values an average of two to five percentage points lower than native-born Americans. However, as immigrants remain in the U.S. longer, their health status begins to deteriorate, eventually converging to unhealthy American BMI levels.²⁶ Researchers attribute this trend to lifestyle factors which contribute to adverse health outcomes, such as poor diet, increased alcohol and cigarette use, and reduced physical activity.²⁷ Immigrants are also less likely to have insurance and a regular source of care, and report more discrimination in health care settings compared to native-born adults in the U.S.²⁸

Among foreign-born nonelderly adults, those with private insurance were more likely (63.1%) to have lived in the U.S. for 18 or more years than those with Medi-Cal (50.2%) or without insurance (49.0%). At 13.2%, the privately insured population had a smaller percentage of recent (0 to 8 years) immigrants than the Medi-Cal (18.2%) and uninsured (20.3%) populations.

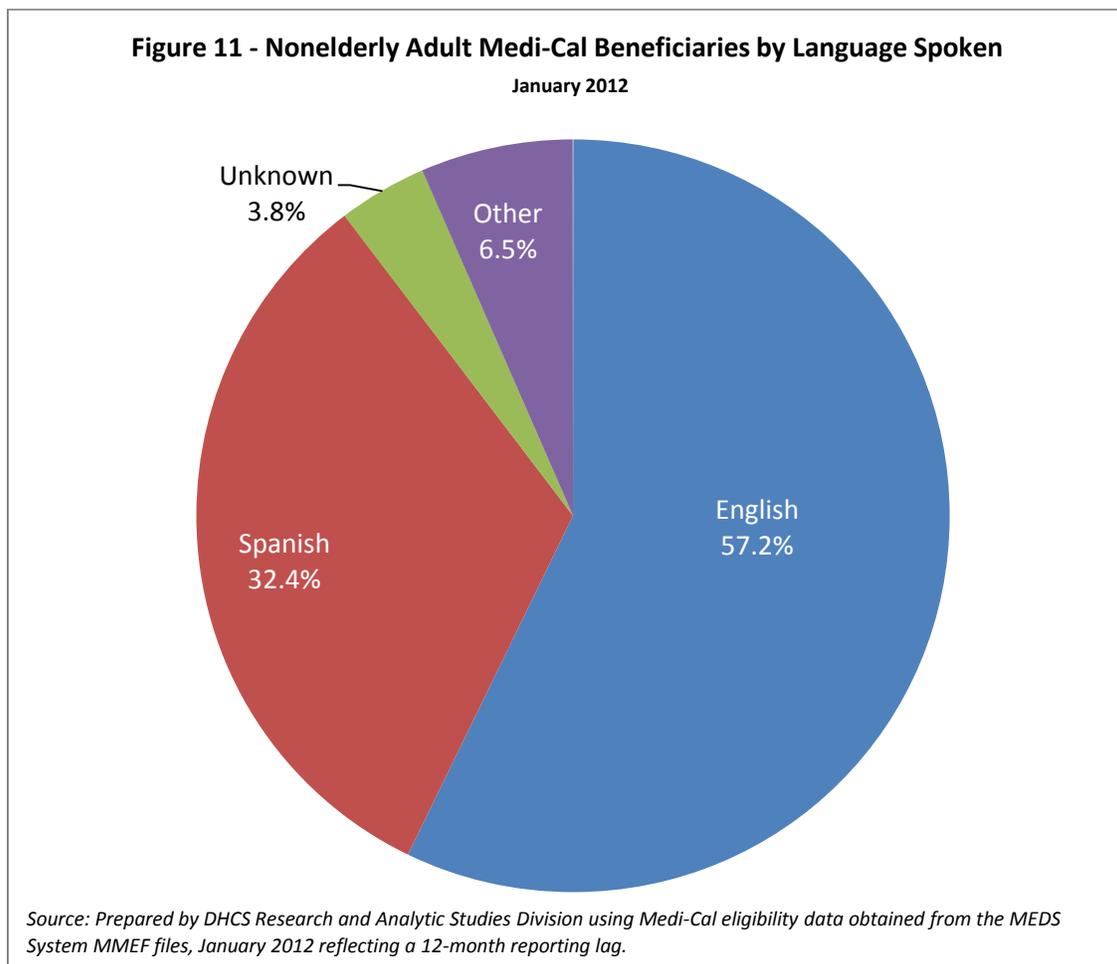


Findings: Language Spoken by the Nonelderly Medi-Cal Population

Derived from DHCS Administrative eligibility data.

Non-financial barriers such as limited English proficiency contribute to disparities in insurance status and access to quality health care.²⁹ Immigrants with limited English proficiency report lower satisfaction with the level of care they received, and a poorer understanding of their medical diagnosis. Limited English proficiency can also affect patient safety due to a poor understanding of instructions, or an adverse reaction to medications.³⁰

More than half of all Medi-Cal beneficiaries reported speaking English as a primary language (57.2%), followed by Spanish (32.4%). A combined category of all other languages accounted for only 6.5% of the Medi-Cal population. The “Other” category represented 26 other languages, including Armenian, Cantonese, Russian, Hmong, Mandarin, and Arabic. [Appendix A, Data Sources and Methods](#), provides a complete breakdown of the languages spoken in the Medi-Cal population.

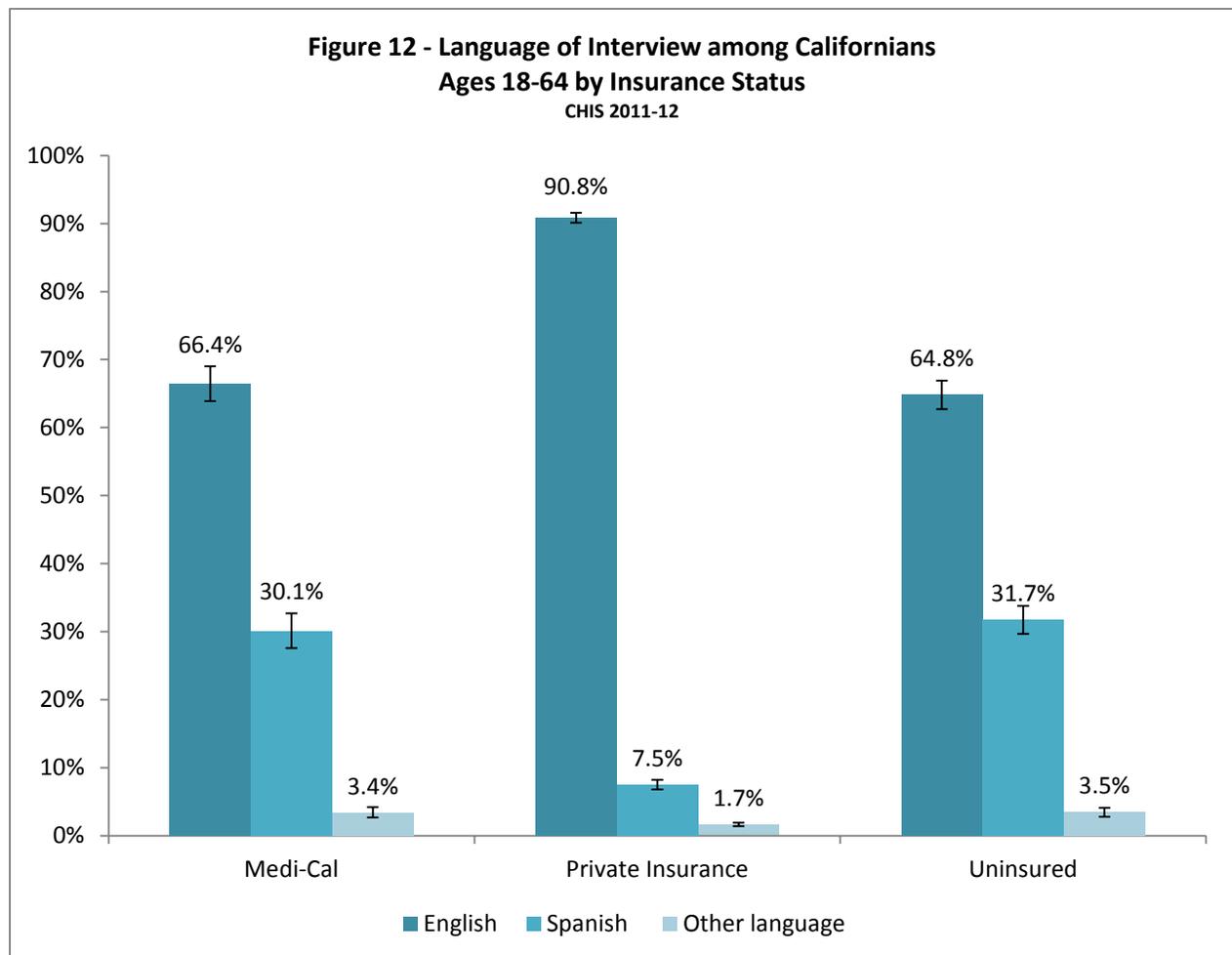


Findings: Language of Interview in California’s Nonelderly Adult Population

CHIS Question: Language in which interviewer conducted CHIS interview.

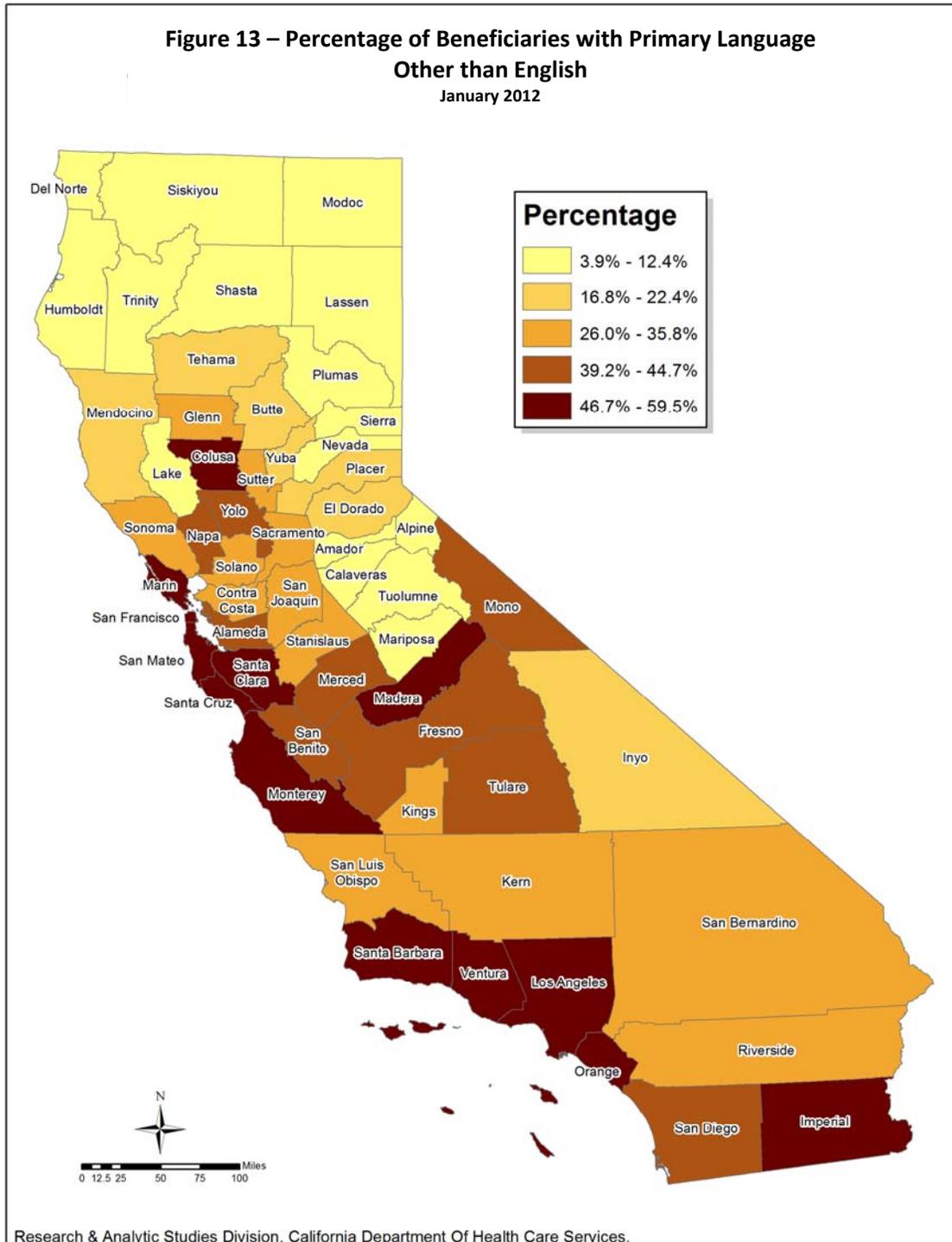
RASD’s findings for the language of CHIS interview for nonelderly adults closely mirrors the language findings derived from DHCS administrative claims data. As noted earlier in this report, 57.2% of nonelderly adult Medi-Cal beneficiaries speak English as a primary language, followed by Spanish (32.4%). A combined category of all other languages accounted for only 6.5% of the Medi-Cal population.

Among Medi-Cal beneficiaries, 66.4% elected to be interviewed in English and 30.1% in Spanish. The proportion conducted in English among nonelderly adults with private insurance was 90.8%. Both the uninsured (3.5%) and Medi-Cal beneficiaries (3.4%) had a higher proportion of interviews conducted in a language other than English or Spanish compared to the privately insured (1.7%).



Findings: Percent of Nonelderly Adult Medi-Cal Beneficiaries with a Primary Language Other than English

Derived from DHCS Administrative eligibility data.



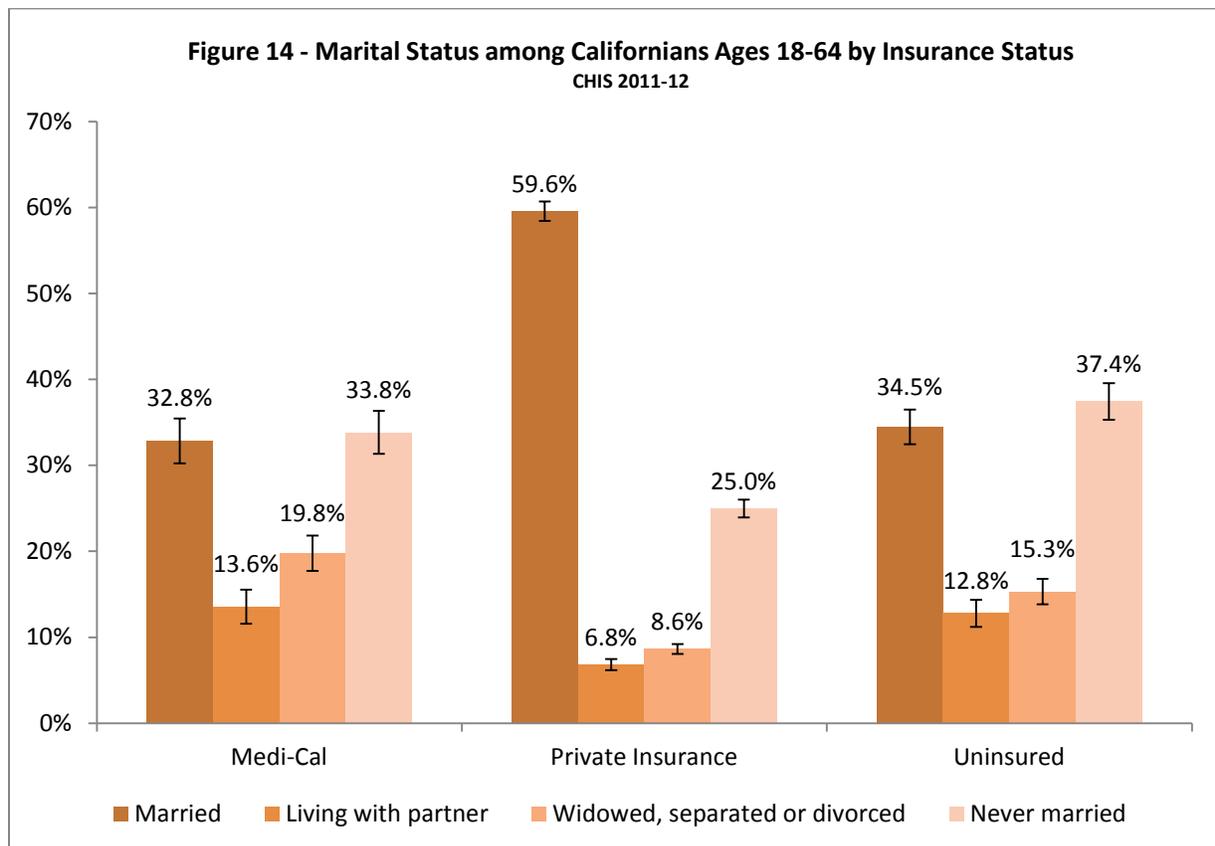
Findings: Marital Status in California’s Nonelderly Adult Population

CHIS Question: “Are you now married, living with partner in a marriage-like relationship, widowed, divorced, separated or never married?”

Marital status correlates with both health status and income. The reviewed literature indicates that married adults are generally healthier than unmarried adults.³¹ This health advantage may begin before marriage; good health increases one’s desirability as a marriage partner and improves the likelihood of marriage. Additionally, research has shown that there are health benefits from being married. Marriage is associated with reduced use of nursing home care, reduced depressive symptoms in both men and women, and an increased likelihood of having health insurance coverage.^{32,33} In general, low-income populations are less likely to be married than those with higher incomes.³⁴

It is important to note that Medi-Cal considers the absence of one parent in a family with children as deprivation and an eligibility pathway for enrollment. The status of single-parenthood as a condition of eligibility may explain the elevated proportion of unmarried adults in Medi-Cal.

Nonelderly adults in California with private insurance were nearly twice as likely to be married (59.6%) as nonelderly adults with Medi-Cal (32.8%) or the uninsured (34.5%). Nonelderly adults with Medi-Cal and the uninsured had similar proportions of their populations living with an unmarried partner, being a widow, separated, or divorced, and having never married (67.2% and 65.5%, respectively).



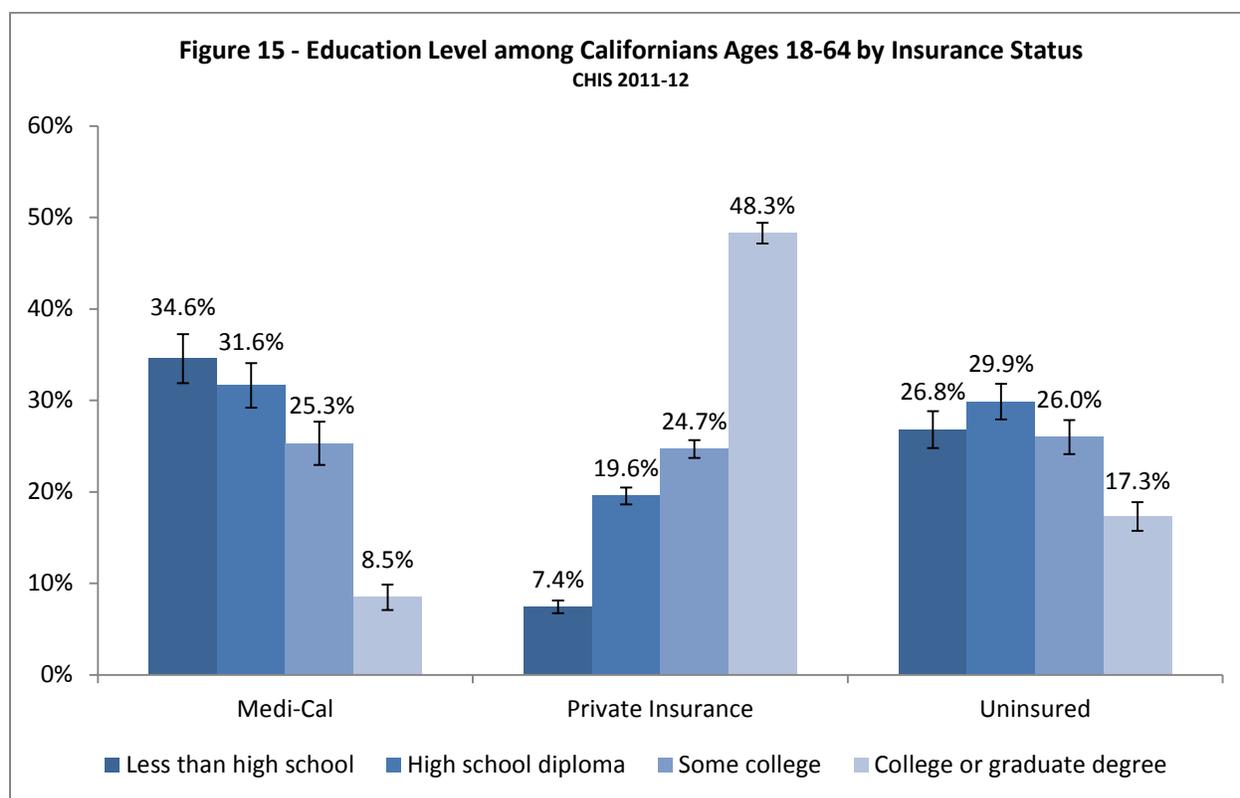
Findings: Education Level in California’s Nonelderly Adult Population

CHIS Question: “What is the highest grade of education you have completed and received credit for?”

A strong and persistent association exists between educational attainment and health status. The reviewed literature shows that morbidity and mortality rates are lower among people with higher educational attainment even after controlling for income, the labor market, and family background.³⁵ Individuals with more education are less likely to report or die from acute or chronic diseases, and less likely to report anxiety or depression.³⁶ Higher levels of education are associated with a lower probability of reporting fair or poor health, a reduced number of days of work lost, and an increase in reported positive health behaviors.³⁷

There is also a strong correlation between educational attainment and income. In 2011, 36.7% of families in which no adult had a high school diploma lived in poverty, compared to 19.9% of families with at least one adult with a high school diploma, and 5.4% of families with at least one adult with a college degree.³⁸

Adults with Medi-Cal coverage had lower educational attainment than the privately insured or uninsured populations. Nonelderly adults enrolled in Medi-Cal were more likely to not have a high school diploma (34.6%) than the uninsured (26.8%) and nonelderly adults with private insurance (7.4%). Individuals with private insurance were more than five times more likely to have a college degree (48.3%) when compared to nonelderly adults with Medi-Cal (8.5%).



Findings: Employment Status in California’s Nonelderly Adult Population

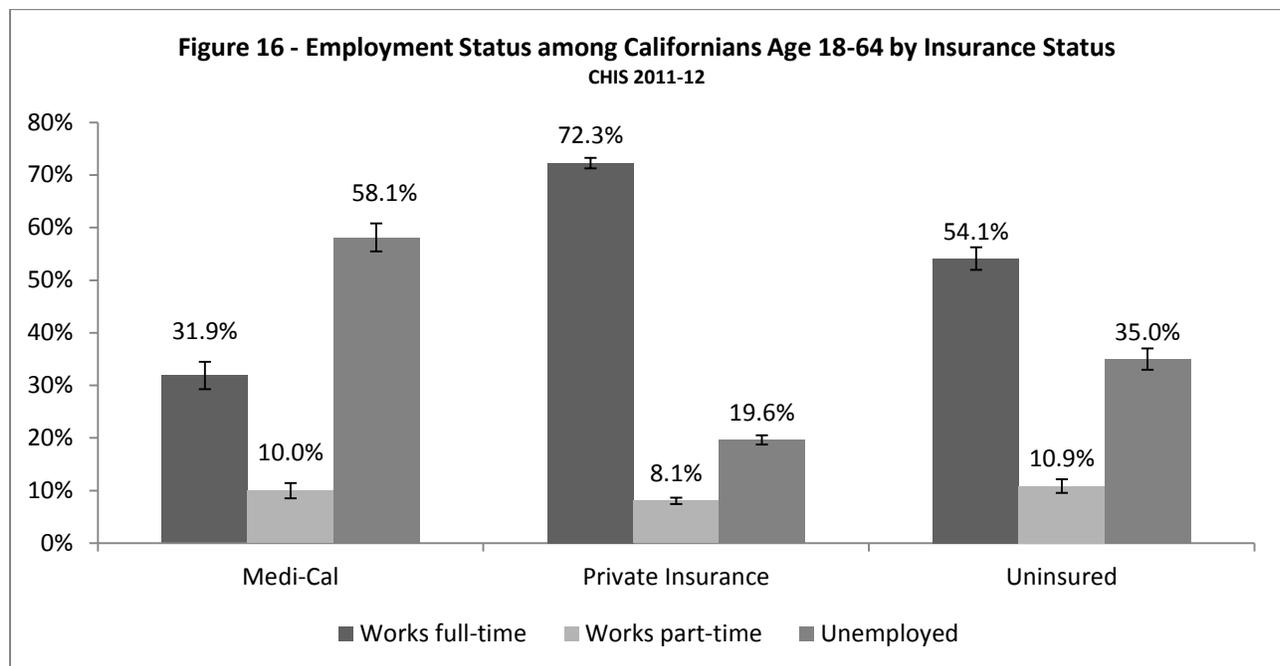
CHIS Question: “How many hours per week do you usually work?”

There is a strong association between unemployment and adverse health outcomes. While some of this disparity may be the advantage of individuals with better health in seeking employment, the reviewed literature suggests that unemployment has measurable health consequences and that long-term unemployment may result in greater mortality.³⁹ This relationship is particularly evident when examining mental health issues, such as depression and substance abuse.⁴⁰ While unemployment is intrinsically linked to income level, the relationship between health and unemployment remains after adjusting for factors such as social class, poverty, age, and pre-existing morbidity.⁴¹

Because Medi-Cal is intended to provide coverage to low- or no-income families and individuals, the relationship between unemployment and income creates a correlation between unemployment and Medi-Cal. Many Medi-Cal eligibility pathways require that enrollees have incomes at or below established low-income thresholds. RASD advises readers to remain mindful of the relationship between income and Medi-Cal eligibility when drawing conclusions from the unemployment data presented in this report.

In 2012, 10.2% of California’s population was unemployed.⁴² Although unemployment declined 1.5% from 2011 to 2012, the health consequences of unemployment remain a relevant issue.⁴³

More than half of nonelderly adults enrolled in Medi-Cal reported being unemployed (58.1%). This was almost three times the proportion among nonelderly adults with private insurance (19.6%) and more than 1.5 times the proportion among nonelderly adults with no insurance (35.0%).



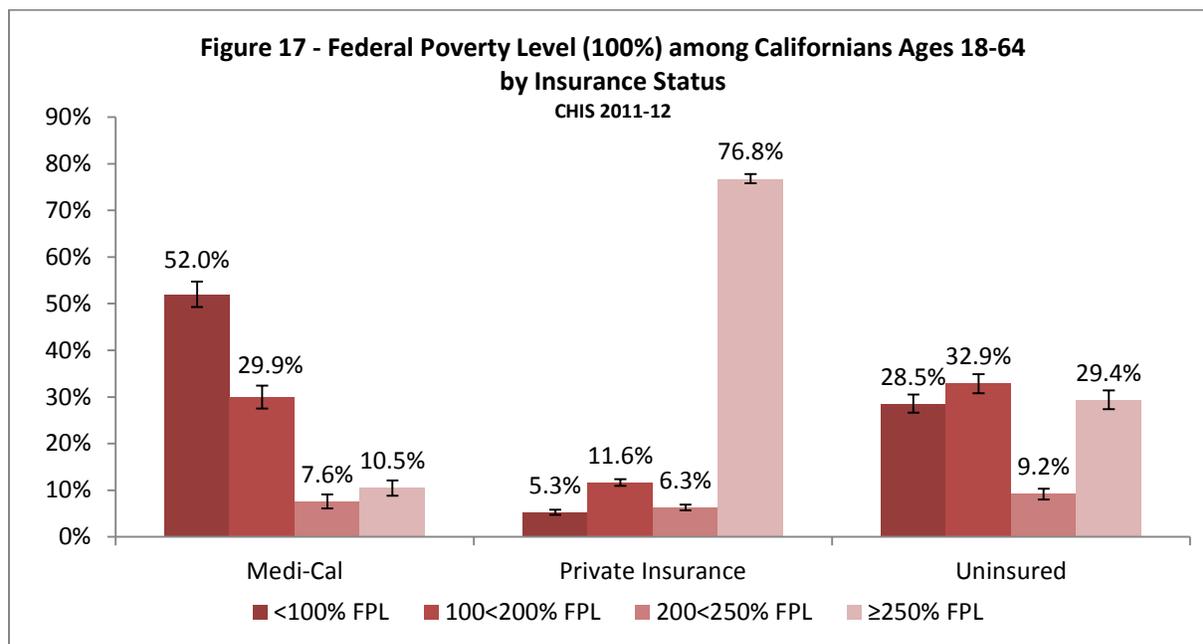
Findings: Federal Poverty Level Status in California’s Nonelderly Adult Population

CHIS Question: “What is the best estimate of your household’s total annual income from all sources before taxes in 2010?”

Health status and income level are strongly related. Low-income individuals have an increased risk of mortality and morbidity, and are less likely to have sufficient access to health care or to receive an adequate quality of care.⁴⁴ Healthy People, a federal organization that identifies long-term health objectives for the U.S. population, recognizes living in poverty as a key determinant of health in a society and an important factor in reducing health disparities.⁴⁵ In the U.S., the standard measure of poverty is the FPL determined by the Department of Health and Human Services. Using household size and income, the FPL allows administrators to measure the proportion and characteristics of the population living in poverty. In 2011, the FPL for a family of four was an income of \$22,350 (100% FPL).⁴⁶

Many Medi-Cal eligibility pathways require that enrollees have incomes at or below established low-income thresholds. RASD advises readers to remain mindful of the relationship between income and Medi-Cal eligibility when drawing conclusions from the income data presented in this report.

More than half (52.0%) of nonelderly adults enrolled in Medi-Cal had incomes below 100% FPL. By contrast, only 28.5% of nonelderly adults without insurance and 5.3% of privately insured nonelderly adults had incomes below 100% FPL. Among the privately insured population, 76.8% had incomes at or above 250% FPL. A substantial percentage of the Medi-Cal (29.9%) and uninsured population (32.9%) had incomes at or above 100% FPL and below 200% FPL.



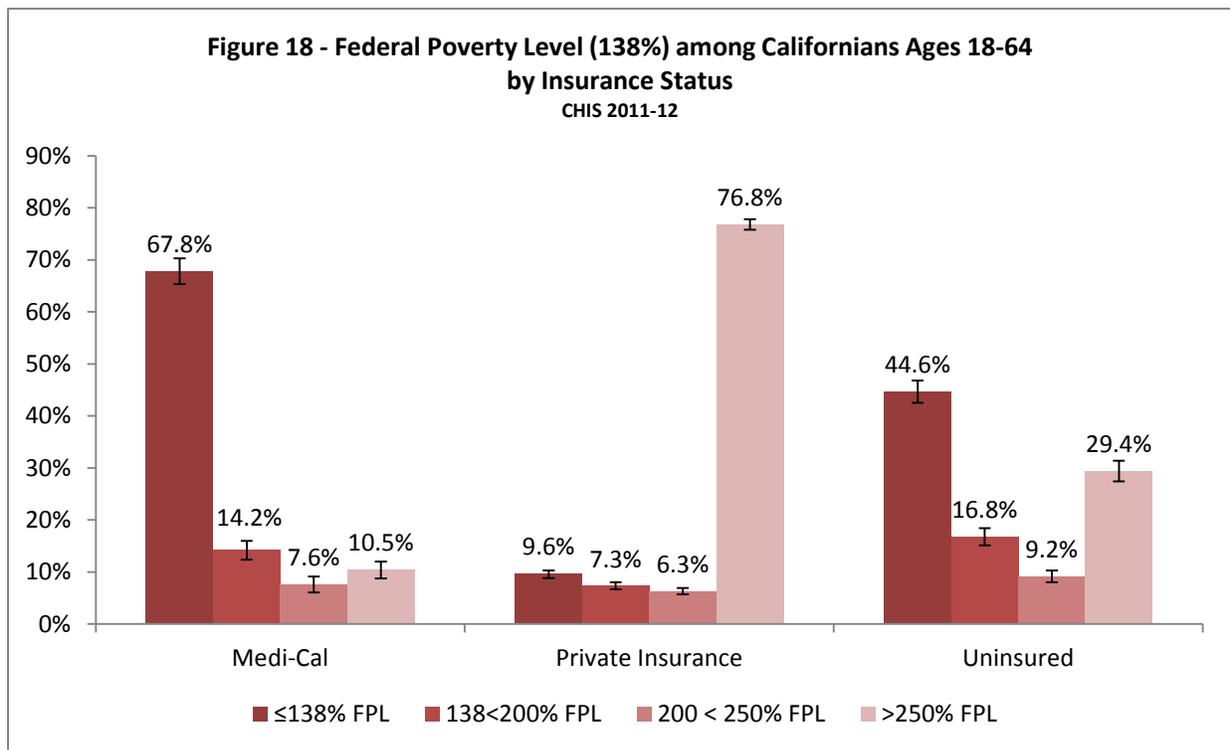
Findings: Federal Poverty Level Status at 138% in California’s Nonelderly Adult Population

CHIS Question: “What is the best estimate of your household’s total annual income from all sources before taxes in 2010?”

Because the ACA creates new eligibility pathways based on FPL, measuring insurance status and income levels are critical monitoring the progress of the implementation. Under the ACA, childless adults with incomes up to 138% FPL are eligible for Medi-Cal. As noted previously in this report, many Medi-Cal eligibility pathways require that enrollees have incomes at or below established low-income thresholds. RASD advises readers to remain mindful of the relationship between income and Medi-Cal eligibility when drawing conclusions based on the income data presented in this report.

Using CHIS data, the chart below depicts the proportion of Medi-Cal enrollees, privately insured, and uninsured Californians with incomes relative to the new ACA eligibility threshold. Almost half of the uninsured nonelderly adults (44.6%) in California have household incomes at or below 138% FPL. Because this population represents those uninsured adults that may become eligible for Medi-Cal under the ACA expansion, tracking this group over the coming years will provide insight into the impact of the ACA.

Among nonelderly adults enrolled in Medi-Cal, 67.8% had household incomes at or below 138% FPL. By contrast, only 9.6% of individuals with private insurance had household income at or below 138% FPL.



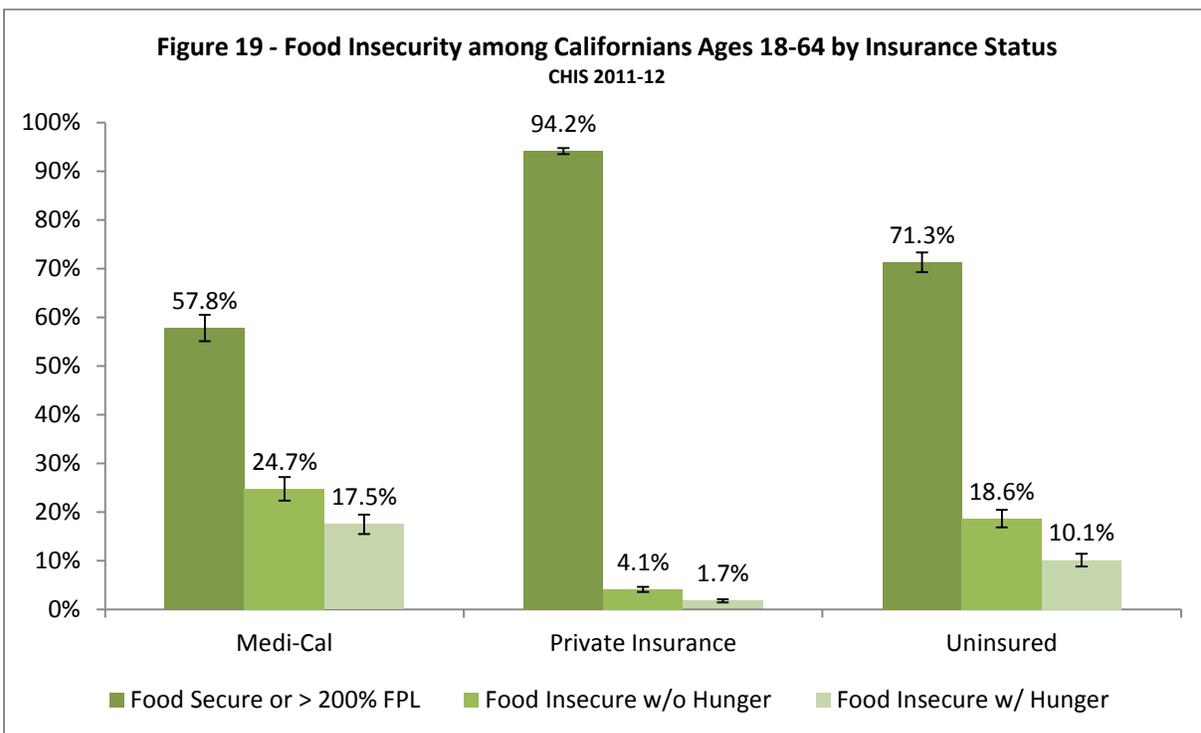
Findings: Food Insecurity in California’s Nonelderly Adult Population

See Appendix A for the questions used to measure food insecurity using CHIS data.

The U.S. Department of Agriculture (USDA) defines food insecurity as an individual or household that, at times, is “uncertain of having, or unable to acquire, enough food to meet needs” due to “insufficient money or other resources for food.”⁴⁷ During 2011, the USDA estimated that 14.9% of households in the U.S. and 15.6% of those in California experienced food insecurity.⁴⁸ Research links food insecurity to numerous physical and mental health complications at all stages of life.⁴⁹ For example, adults who experience moderate to severe food insecurity are more likely to be obese and develop type 2 diabetes than adults who are not food-insecure.^{50,51} Food insecurity in children correlates to malnutrition, poor academic performance, and behavioral issues.⁵²

RASD constructed this food insecurity measure from several CHIS questions addressing the availability and affordability of food. A description of the questions used to measure food insecurity is located in [Appendix A](#), Data Sources and Methods. The chart below depicts three food security statuses: food security, food insecurity without experiencing hunger, and food insecurity with hunger.

Nonelderly adults enrolled in Medi-Cal were more likely to experience food insecurity without hunger (24.7%) and food insecurity with hunger (17.5%) when compared with the privately insured and uninsured populations. Food insecurity both with hunger (1.7%) and without hunger (4.1%) was considerably lower in the privately insured population.

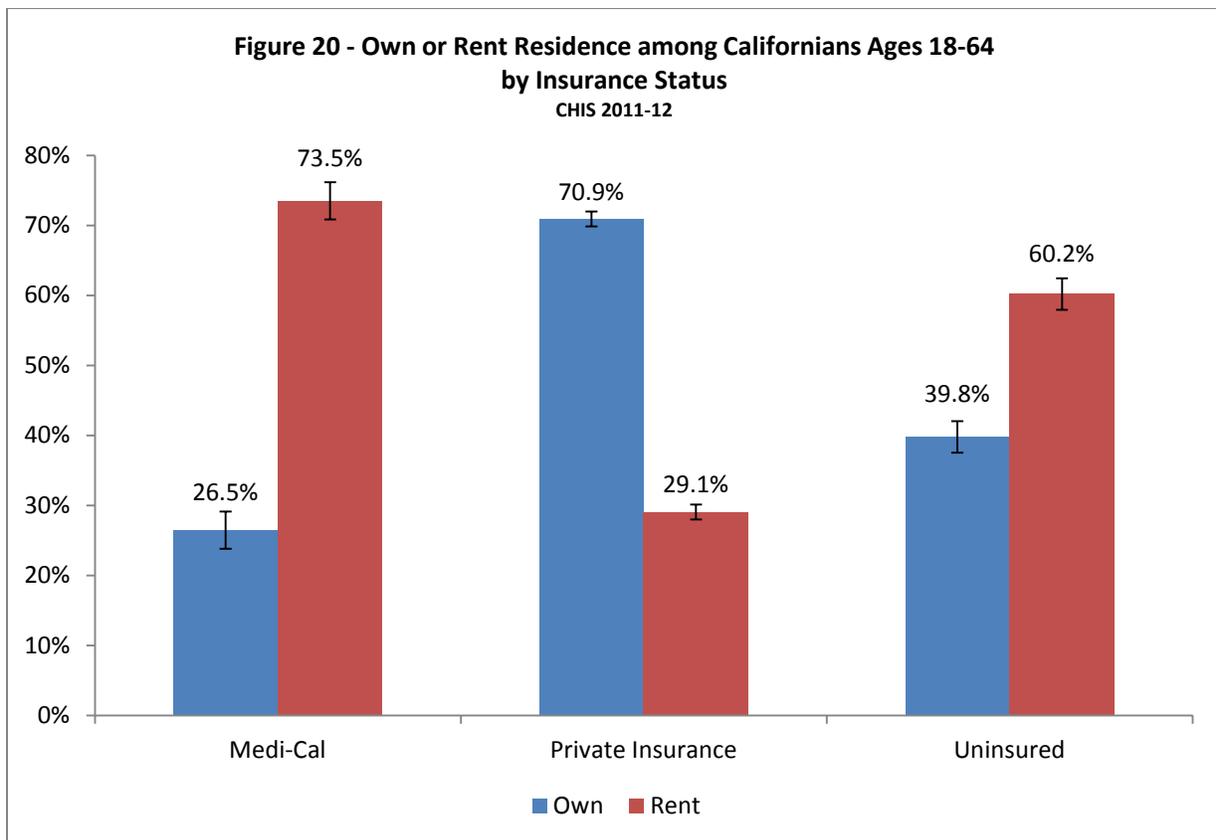


Findings: Renting/Owning a Home in California’s Nonelderly Adult Population

CHIS Question: “Do you own or rent your home?”

Homeownership is associated with improved health outcomes and social benefits.⁵³ Many of the health advantages of homeownership correspond with the tendency of homeowners to maintain healthier residences that promote better living conditions. Renters are more likely to suffer from health conditions associated with residential dampness, toxicity, or allergens.⁵⁴ Historically, researchers have associated homeownership with positive mental health outcomes, including greater life satisfaction.⁵⁵ However, recent studies suggest that the stresses of homeownership may negate some or all of the emotional health advantages for some population groups.⁵⁶ Home foreclosures, which are more common in low-income areas, negatively affect the mental health of residents.⁵⁷

Only 26.5% of nonelderly adults enrolled in Medi-Cal owned their home, compared to 39.8% of the uninsured and 70.9% of nonelderly adults with private insurance.



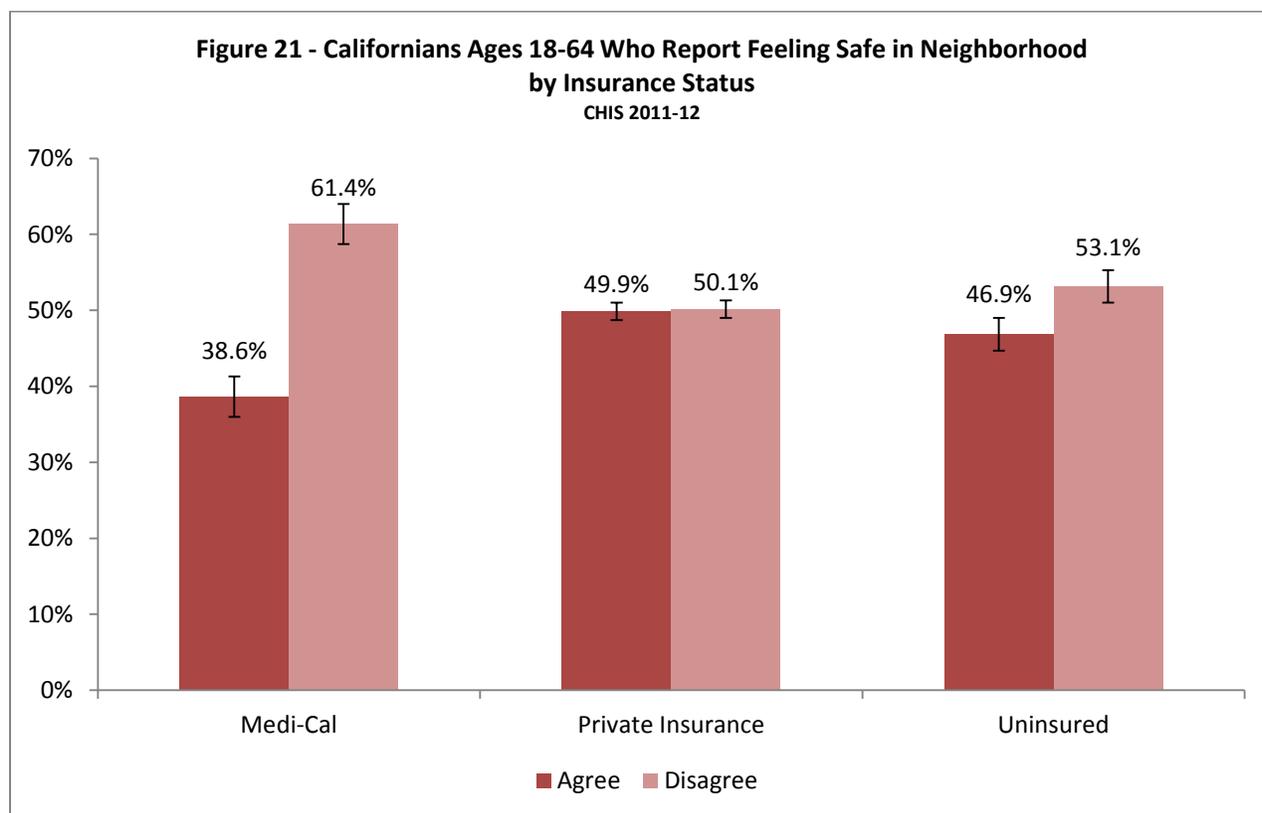
Findings: Feeling of Safety in the Neighborhood in California’s Nonelderly Adult Population

CHIS Question: “Do you feel safe in your neighborhood? Strongly agree, agree, disagree, or strongly disagree?”

The social and economic features of a neighborhood affect the mortality, health status, and health behaviors of the population who lives there.⁵⁸ Neighborhoods influence health through physical factors, such as poor air and water quality, unsafe housing, and limited access to healthy food and safe exercise spaces. Less obvious social factors in a neighborhood can also affect the health of the residents. For example, neighborhoods where residents reported feeling less close-knit experience increased rates of negative mental health outcomes and health-damaging behaviors like smoking and drinking.⁵⁹

For the purpose of this analysis, RASD defined adults that answered “strongly agree” or “agree” to the question above as feeling safe in their neighborhood.

Of all the studied populations, nonelderly adults enrolled in Medi-Cal were least likely to report feeling safe in their neighborhood (38.6%). The privately insured population was divided evenly between those who felt safe and those who did not (49.9% and 50.1%, respectively).



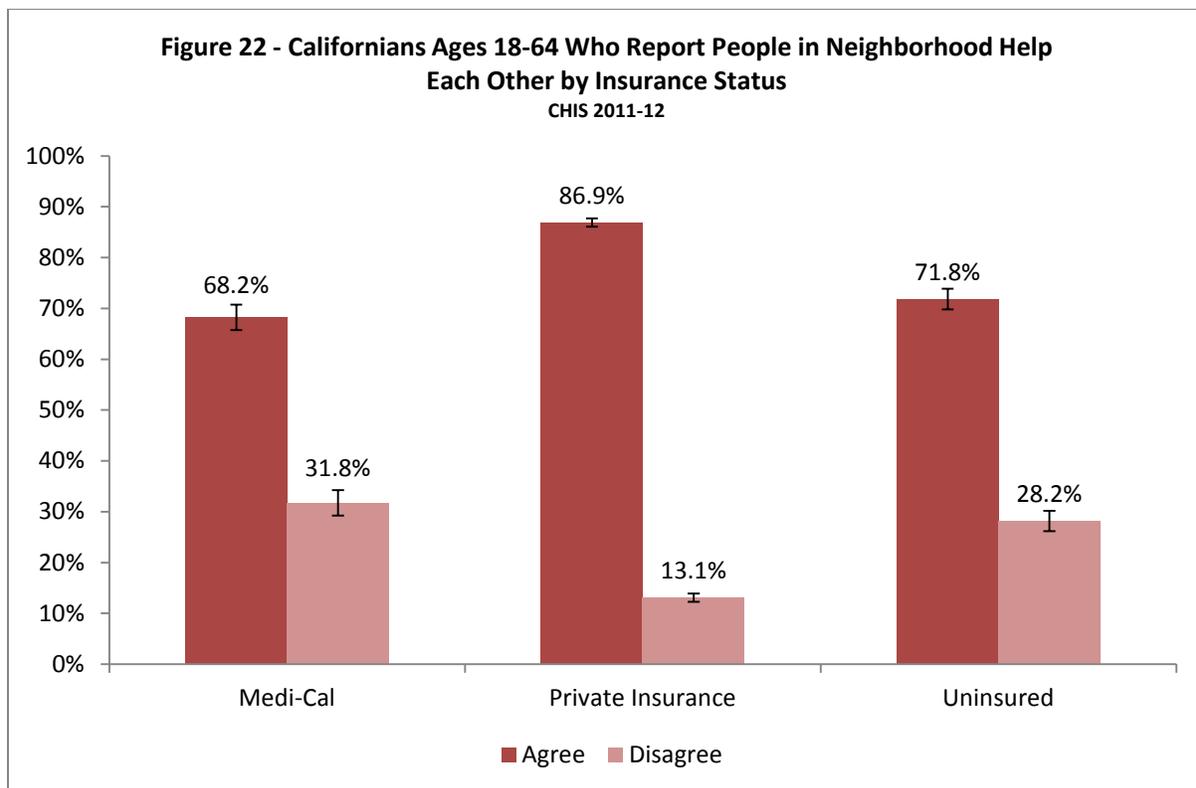
Findings: Feeling that Neighbors Help One Another in California’s Nonelderly Adult Population

CHIS Question: “People in my neighborhood are willing to help each other. Strongly agree, agree, disagree, or strongly disagree?”

Like physical health hazards, the social environments of neighborhoods can influence the health outcomes of the residents. For example, neighborhoods where residents report feeling less close-knit experience increased rates of negative mental health outcomes and health-damaging behaviors like smoking and drinking.⁶⁰ Similarly, research indicates that higher levels of neighborhood social cohesion correlate with better physical and mental health outcomes.⁶¹ A resident’s willingness to help neighbors is a common indicator of the level of cohesion in a community.⁶²

For the purpose of this analysis, RASD defined adults that answered “strongly agree” or “agree” to the above question as living in a neighborhood where individuals were willing to help each other.

Nonelderly adults with private insurance (86.9%) and the uninsured (71.8%) were more likely than those enrolled in Medi-Cal (68.2%) to feel that people in their neighborhood were willing to help each other. This pattern mirrors the findings in the other community cohesion measures reported by RASD.



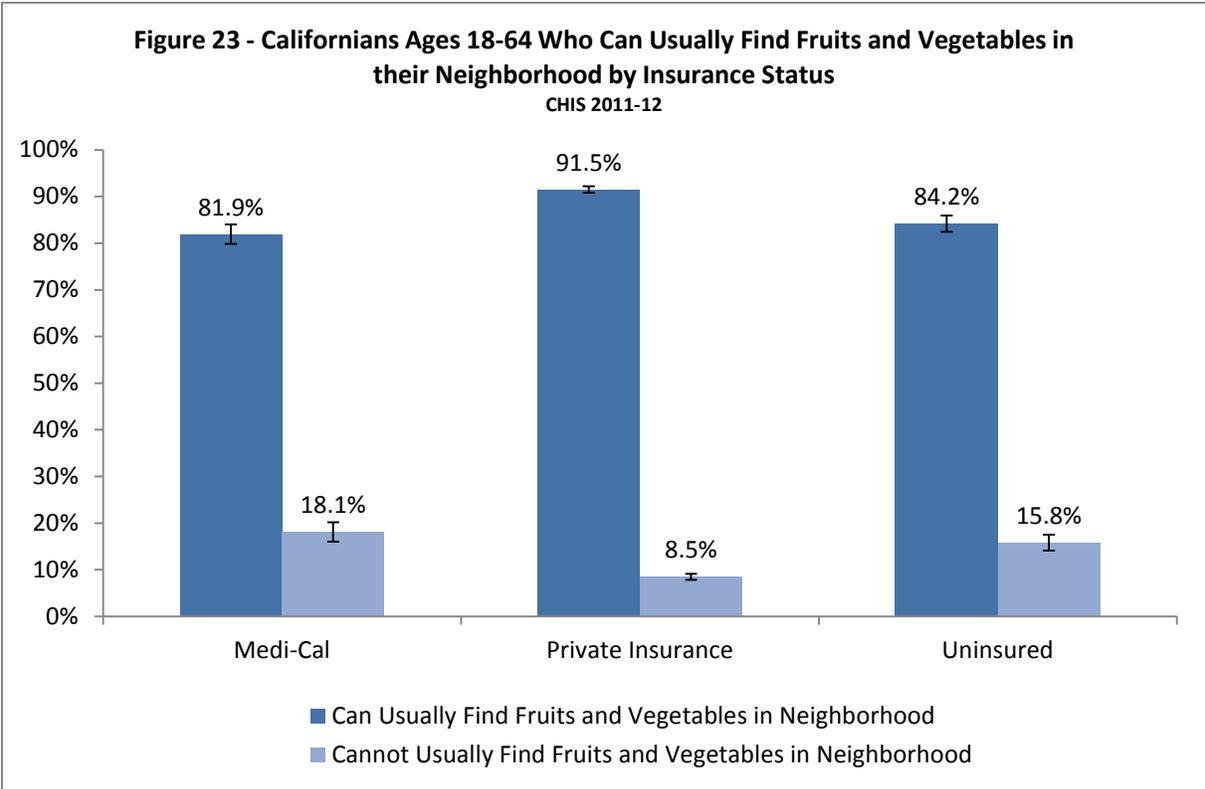
Findings: Ability to Find Fruit and Vegetables in the Neighborhood in California’s Nonelderly Adult Population

CHIS Question: “How often can you find fruits and vegetables in your neighborhood? Never, sometimes, usually or always?”

Access to healthy food has serious effects on health and wellbeing.⁶³ Individuals who do not have access to healthy food through grocery stores, farmer’s markets, or produce vendors have a harder time lowering fat intake, maintaining a healthy diet, and meeting federal dietary guidelines.⁶⁴ In addition to correlating with these negative health behaviors, access to healthy food correlates with health status. Individuals who report poor health are four times more likely to have trouble accessing healthy food than those who report excellent health.⁶⁵ Neighborhood resources have a substantial impact on the health outcomes of residents even when residents are making a conscious effort to make healthy choices.⁶⁶

For the purpose of this analysis, RASD defined respondents who answered “usually” or “always” to the above question as able to find fruits and vegetables in their neighborhood, and those who responded “sometimes” or “never” as not usually able to find fruits and vegetables in their neighborhood.

Nonelderly adults enrolled in Medi-Cal were more than twice as likely (18.1%) as nonelderly adults with private insurance (8.5%) to report trouble finding fruits and vegetables in their neighborhood.



Findings: Ability to Find Affordable Fruit and Vegetables in the Neighborhood in California’s Nonelderly Adult Population

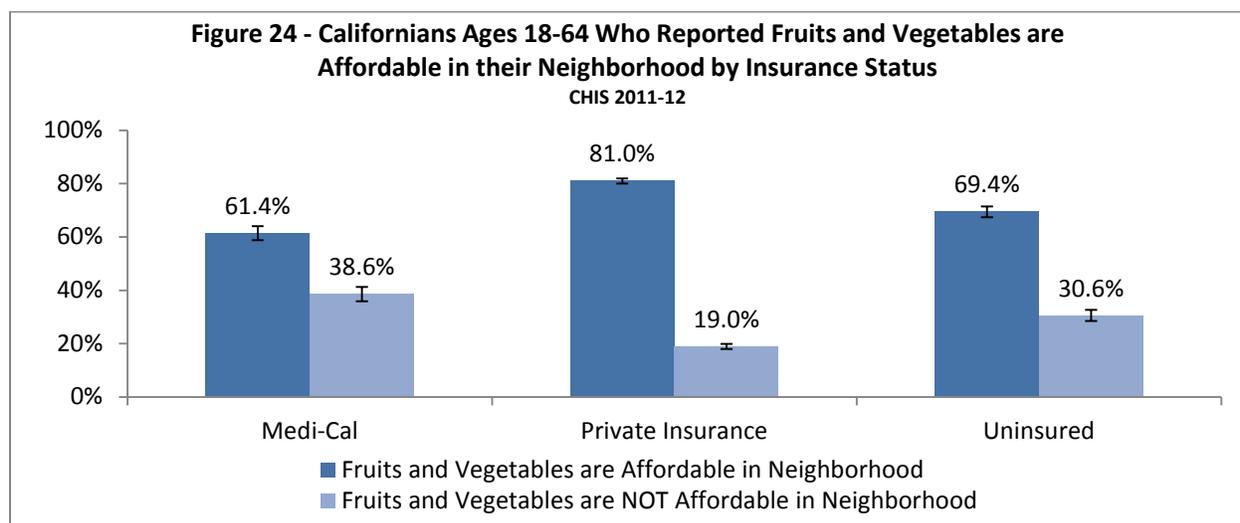
CHIS Question: “How often are they affordable? Never, sometimes, usually or always?”

Low-income areas are less likely to have healthy food options, making the affordability of available healthy food an important factor in access. A study of food availability in the U.S. found that wealthy census tracts had, on average, twice as many supermarkets as low-income census tracts.⁶⁷ This limited availability compounds the budgetary concerns of low-income families. Because families with modest food budgets are motivated to prioritize low-cost, energy-rich foods, fruits and vegetables represent less efficient calories than cheaper starches, sugars, and vegetable fats.⁶⁸ Energy-dense fats and starches are often the cheaper and more convenient option for low-income populations, while fresh produce is more expensive, harder to come by, and involves greater spoilage and cooking costs.⁶⁹

Access to fruits and vegetables correlates with positive health behaviors, an increased ability to meet federal dietary guidelines, and improved health outcomes.⁷⁰ When studying low-income populations like Medi-Cal beneficiaries, it is important that stakeholders consider the affordability of healthy foods as an impediment that compounds issues of physical access to healthy foods.

For the purpose of this analysis, RASD defined respondents who answered “usually” or “always” to the above question as able to find affordable fruits and vegetables in their neighborhood and those who responded “sometimes” or “never” as not usually able to find affordable fruits and vegetables in their neighborhood. Respondents who do not eat or shop for fruits and vegetables were not included in the analysis.

Among the studied population groups, nonelderly adults enrolled in Medi-Cal were least likely (61.4%) to find affordable fruits and vegetables in their neighborhood. Affordable fruits and vegetables were available to a greater percentage of nonelderly adults with private insurance (81.0%) or no insurance (69.4%).



Findings: Smoking in California's Nonelderly Adult Population

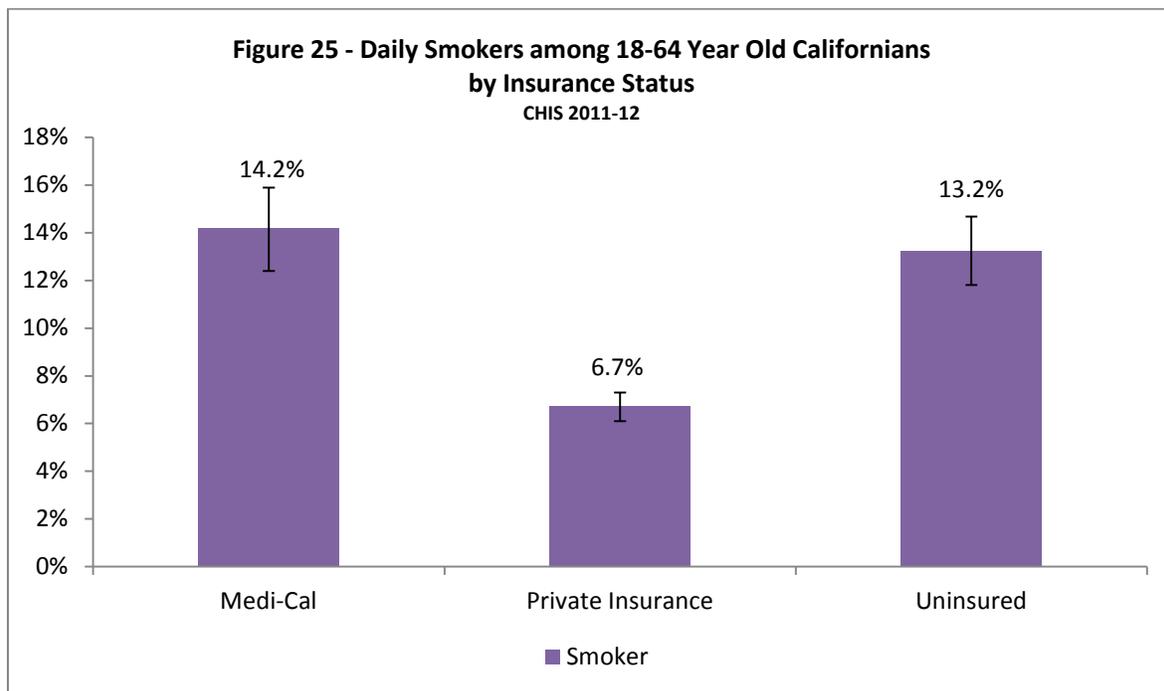
CHIS Question: "Altogether have you smoked 100 or more cigarettes in your lifetime? Did you smoke every day, some days or not at all?"

Cigarette smoking is the single most preventable cause of death and disease in the United States.⁷¹ Research has causally linked smoking to diseases of almost every organ of the body, including many types of cancers, heart disease, and lung disease.⁷² Smoking increases the chance of developing lung cancer by over 25% and accounts for approximately 90% of all lung cancer deaths in the U.S.⁷³ Smoking is also associated with a number of chronic health concerns, such as general bodily inflammation, reduced immunity, reduced sperm count, and decreased tooth and gum health.⁷⁴ Maternal smoking increases the chance of premature birth, low birth weight, stillbirth, and infant death.⁷⁵

Smoking is more common among low-income populations in the U.S.⁷⁶ In 2012, 27.9% of U.S. adults with incomes below 100% FPL smoked, compared to 17.0% of U.S. adults with incomes at or above 100% FPL.⁷⁷

For the purpose of this analysis, RASD considered nonelderly adults who smoked at least 100 cigarettes in their lifetime and smoked every day as daily smokers.

Nonelderly adults enrolled in Medi-Cal were more than twice as likely (14.2%) to be daily smokers when compared to adults with private insurance (6.7%). A substantial percentage of uninsured nonelderly adults were daily smokers (13.2%).



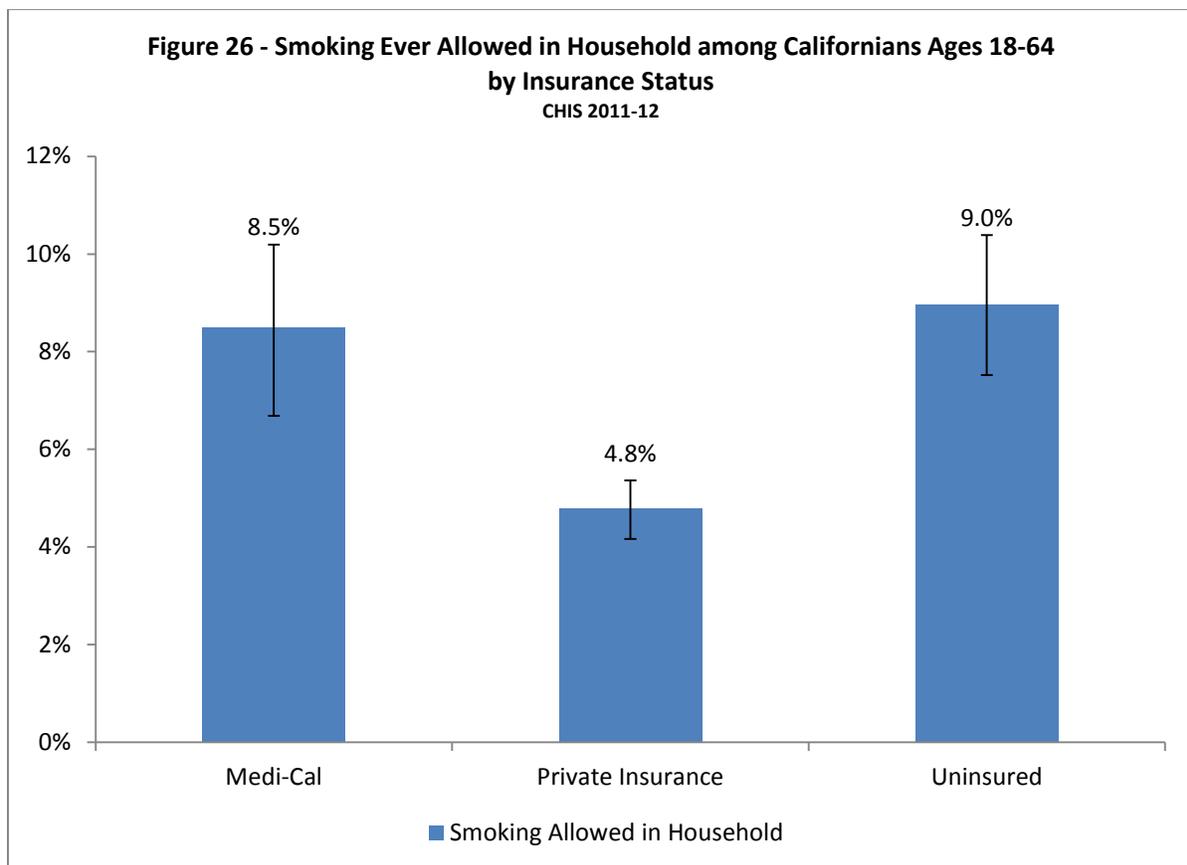
Findings: Smoking in the Household in California’s Nonelderly Adult Population

CHIS Question: “Is smoking ever allowed in your home?”

The health consequences of smoking extend beyond the smoker to their household and community. The Centers for Disease Control and Prevention (CDC) defines secondhand smoke as a “combination of smoke from the burning end of a cigarette and the smoke breathed out by smokers.”⁷⁸ Increased exposure to secondhand smoke increases the risk for many of the same conditions found in cigarette smokers, including cardiovascular disease, stroke, and lung cancer.⁷⁹ Research indicates that secondhand smoke is especially harmful for children. Children exposed to secondhand smoke have an increased chance of developing asthma, and are more likely to suffer from ear infections and other illness than children not exposed to secondhand smoke.⁸⁰

Because exposure to secondhand smoke has serious health consequences, it is important for stakeholders to examine the number of households that allow smoking in the home in addition to the number of cigarette smokers in a population.

The proportion of nonelderly adults that allowed smoking in their home was similar among nonelderly adults enrolled in Medi-Cal (8.5%) and those without insurance (9.0%), but considerably lower among adults with private insurance (4.8%).



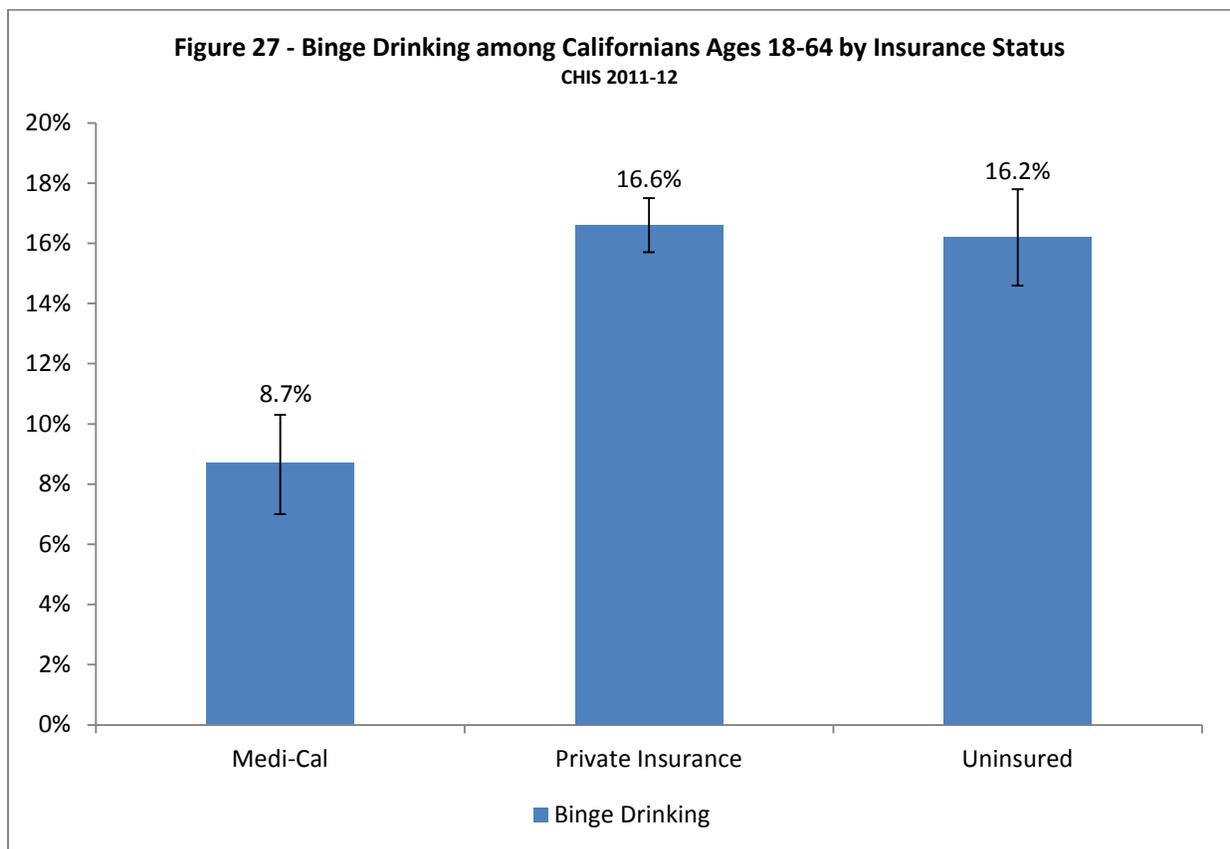
Findings: Binge Drinking in California's Nonelderly Adult Population

CHIS Question: "In the past 12 months how many times did you have 5 [4 for women] or more alcoholic drinks in a single day?"

In the U.S., a two-hour drinking episode that results in a blood alcohol concentration above 0.08% is considered binge drinking.⁸¹ Although most binge drinkers do not have an alcohol dependency, binge drinking is associated with a myriad of negative health outcomes including neurological damage, liver disease, stroke, sexual dysfunction, and alcohol poisoning.⁸² Despite the associated health consequences, the CDC estimates that binge drinking accounts for more than half of all alcohol consumed in the U.S.⁸³ In 2010, 17.1% of U.S. adults reported binge drinking, with an average of 8 drinks consumed in an episode.⁸⁴

For the purpose of this analysis, RASD defined binge drinking as five or more drinks in a single day for men and four or more drinks in a single day for women, occurring monthly or more often in the past year.

Unlike many of the health behaviors highlighted in this report, binge drinking is more frequent among high-income populations in the U.S.⁸⁵ RASD's analysis found that adults enrolled in Medi-Cal were less likely (8.7%) to binge drink than adults with private insurance (16.6%), and adults without insurance (16.2%).

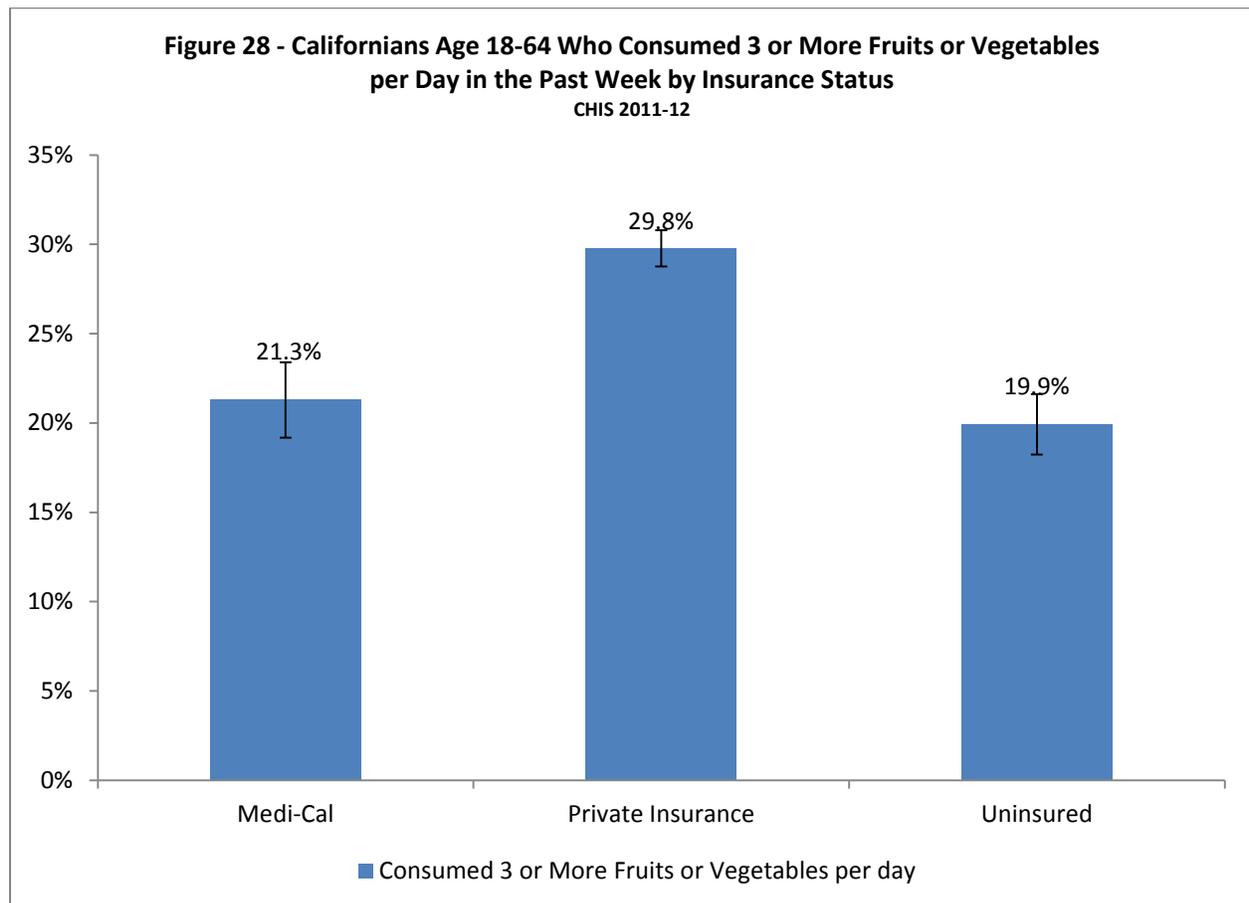


Findings: Eating Three or More Fruits or Vegetables per Day in California's Nonelderly Adult Population

CHIS Question: "How many times did you eat fruit? How many times did you eat vegetables?"

The *Dietary Guidelines for Americans* issued by the USDA suggests that Americans increase their intake of fruits and vegetables, especially vegetables that are dark green, orange, or red in color.⁸⁶ The USDA estimates that the average American consumes only 59% of the recommended vegetable intake and 42% of the recommended fruit intake, despite the well-established health benefits.⁸⁷ Several recent studies have associated dietary factors to the cause and prevention of chronic diseases, including cancer, coronary heart disease, birth defects, and cataracts.^{88,89} Routinely consuming fruits and vegetables reduces the risk of cancer, stroke, and Alzheimer's disease.⁹⁰

Only 21.3% of nonelderly adults enrolled in Medi-Cal ate three or more fruits or vegetables per day in the past week. The rate was higher among adults with private insurance (29.8%) and similar among adults with no insurance (19.9%).



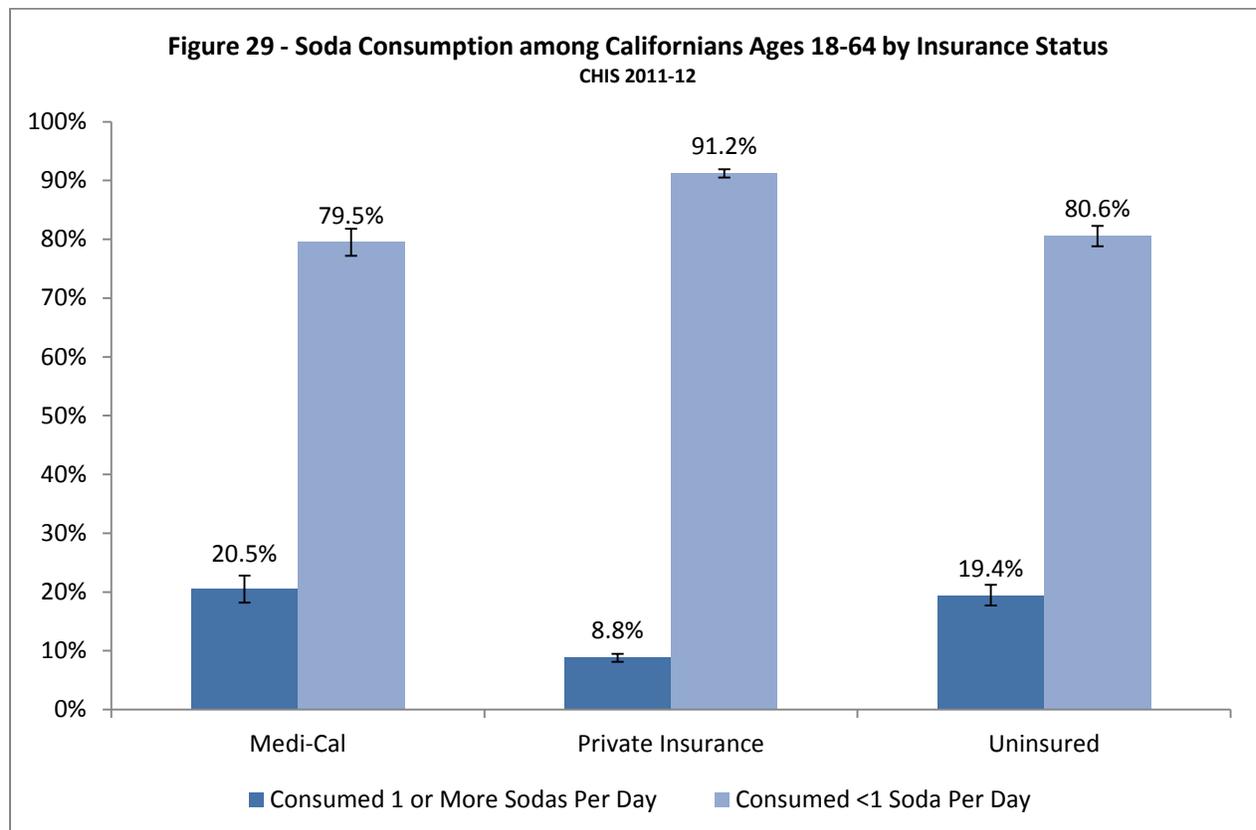
Findings: Soda Consumption in California’s Nonelderly Adult Population

CHIS Question: “How often do you drink regular soda or pop that contains sugar?”

Sugar-sweetened beverages, such as soda, provide little nutritional benefit while containing a high concentration of calories. In the U.S., the average person consumes 200 calories a day in soda, representing 10% of the recommended daily caloric intake.⁹¹ Further, because liquid calories do not give a sensation of fullness associated with solid food, they encourage consumers to add calories to their usual diet.⁹² Consuming soda is associated with the decreased intake of fruits and vegetables, and the increased occurrence of tooth decay, obesity, and obesity-related conditions (type 2 diabetes, high cholesterol, and high blood pressure).⁹³

The reviewed literature indicates that the increase of soda consumption in recent decades, especially in low-income populations, is a major factor in the increased prevalence of obesity in the U.S.⁹⁴ The relationship between soda consumption and income disparity makes it an important area of study for Medi-Cal stakeholders.

Daily soda consumption was more than twice as common among nonelderly adults enrolled in Medi-Cal (20.5%) and those without insurance (19.4%) than nonelderly adults with private insurance (8.8%)



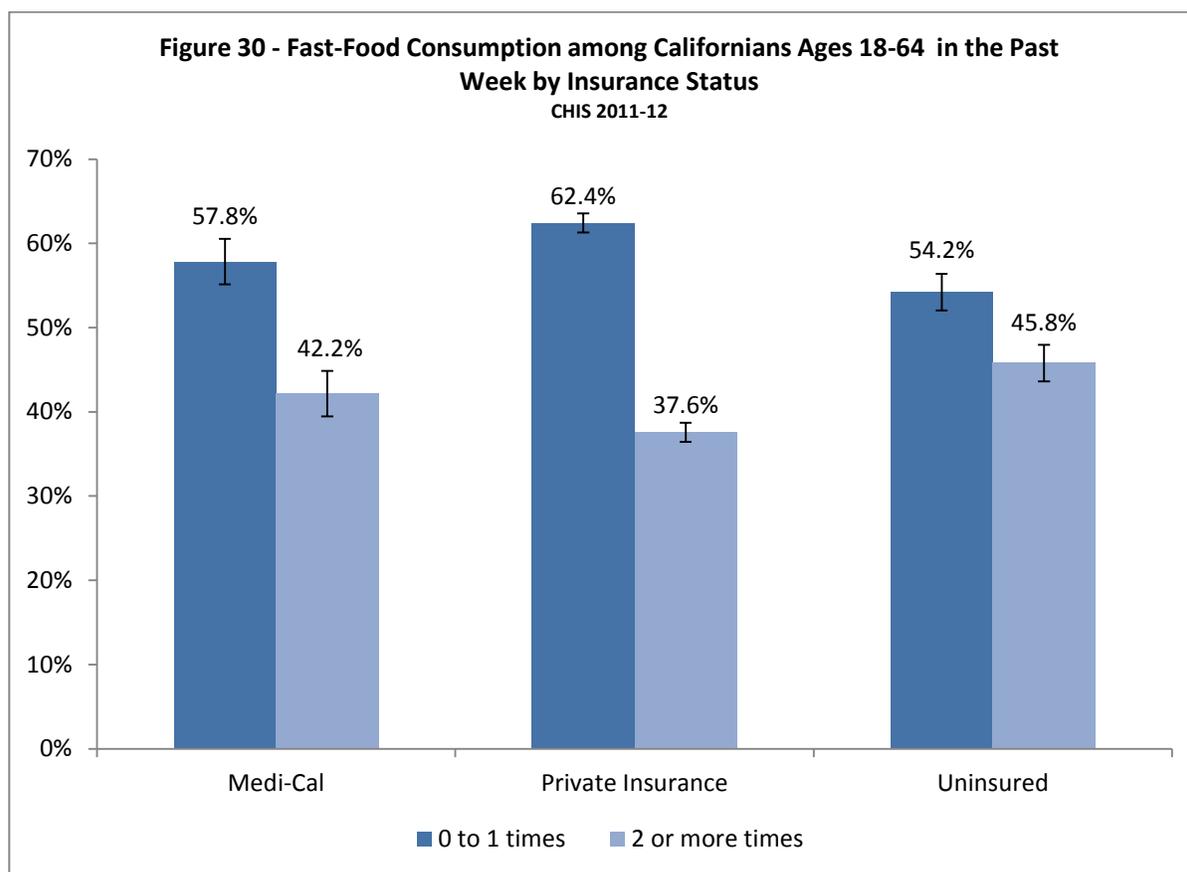
Findings: Fast-Food Consumption in California’s Nonelderly Adult Population

CHIS Question: “In the past 7 days, how many times did you eat fast food?”

Although fast-food consumption has, on average, decreased in the U.S. in recent years, it still accounts for a substantial percentage of the nation’s calories.⁹⁵ From 2007 to 2010, American adults received 11.3% of their average calorie intake from fast food.⁹⁶ Regular fast-food consumption has been associated with higher fat intake, and lower intake of healthy nutrients.⁹⁷ Frequently ingesting fast food contributes to increased weight gain due to the greater intake of calories, fat, saturated fat, and sugar-sweetened drinks.^{98,99} More than one-third of U.S. adults are obese and the prevalence of obesity increased consistently with regular fast-food consumption.^{100,101}

Fast-food consumption is relevant for Medi-Cal stakeholders as some studies indicate a relationship between low-income adults and increased fast-food consumption. A study of adults ages 20 to 39 found that the percentage of daily calories attributed to fast food decreased significantly as incomes increased.¹⁰²

Nonelderly adults enrolled in Medi-Cal were less likely to eat fast food two or more times per week (42.2%) than nonelderly adults without insurance (45.8%), but more likely than nonelderly adults with private insurance (37.6%).

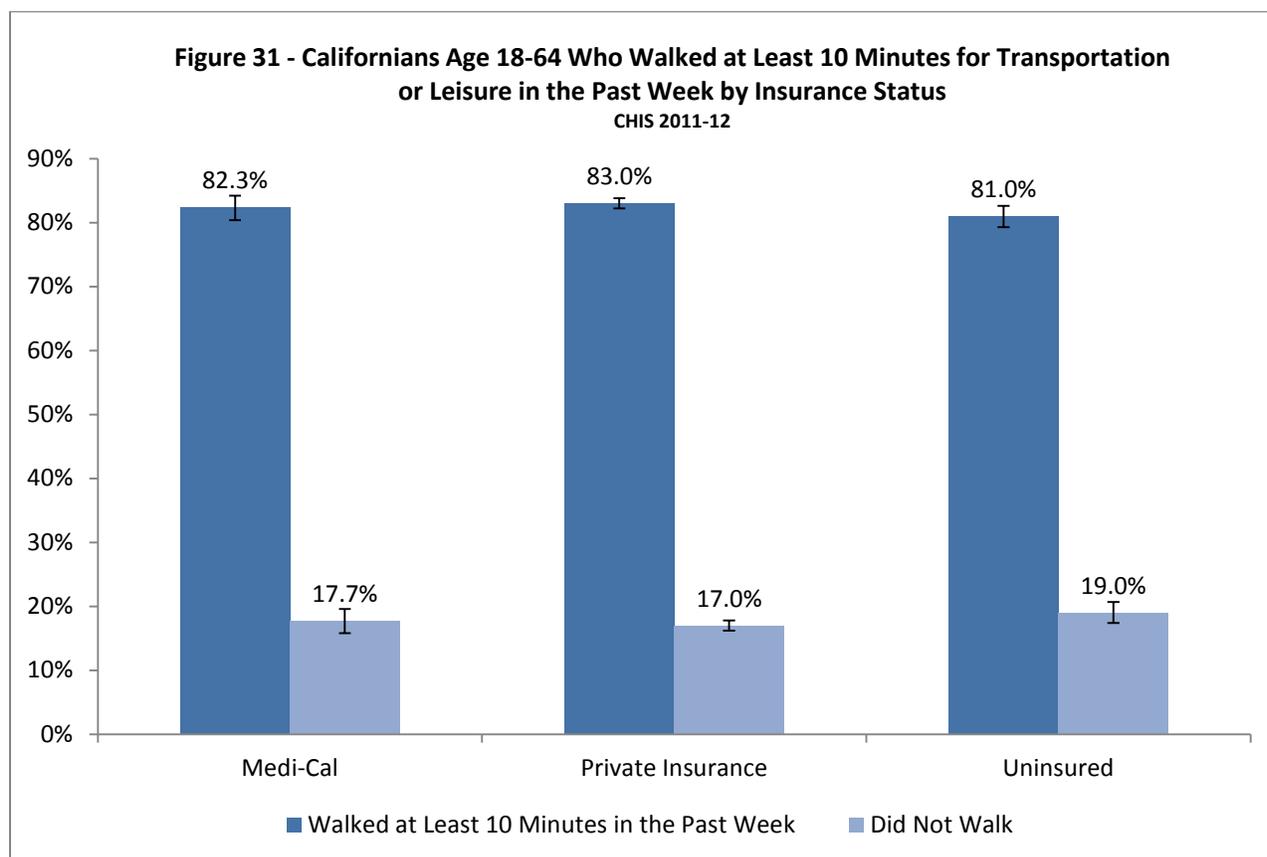


Findings: Walking for 10 Minutes in California’s Nonelderly Adult Population

CHIS Question: “In the past 7 days, did you walk to get some place that took you at least 10 minutes?”

Walking is a simple, low-risk activity that can considerably improve health and reduce rates of chronic disease.¹⁰³ Physical inactivity contributes to obesity and is a major risk factor in many adverse health outcomes related to obesity, including hypertension, cardiovascular disease, diabetes mellitus, and all-cause mortality.¹⁰⁴ Small amounts of physical activity prevent weight gain in most populations.¹⁰⁵ A collation of recent walking studies found that over an average period of 11.3 years, walking reduced the chance of a cardiac event by 31% and the risk of dying by 32%.¹⁰⁶ Further, the health benefits of walking are cumulative; walking farther, more often, or faster increases the health benefits.¹⁰⁷

The proportion of nonelderly adults in the study population who did not walk for at least 10 minutes in the past week was similar for nonelderly adults on Medi-Cal (17.7%), those with private insurance (17.0%), and those without insurance (19.0%).



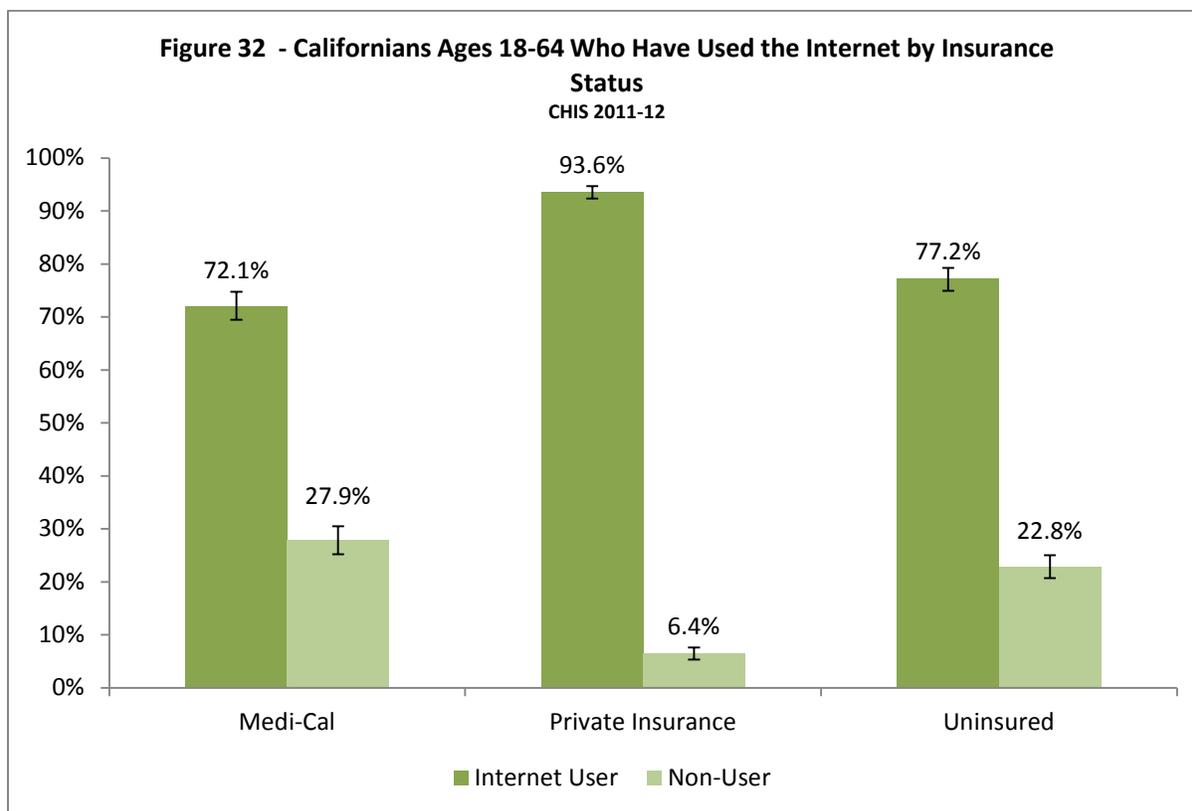
Findings: Internet Use in California's Nonelderly Adult Population

CHIS Question: "Have you ever used the internet?"

In 2011, 78% of adults in the U.S. had access to the internet and more than half of adults (59%) reported using the internet to research health topics.¹⁰⁸ Of adults self-diagnosing a condition using the internet, 35% do not visit a doctor or clinician to confirm their diagnosis.¹⁰⁹ Further, emerging research indicates that internet access may correlate with health status. For example, 82% of adults without a chronic condition report having internet access, compared to only 72% of adults with a chronic condition.¹¹⁰ The relationship between internet access and health status requires further study, due to the social and economic factors shared by populations with poor health outcomes and reduced access to the internet.¹¹¹

Populations less likely to have internet access share many traits with the Medi-Cal population, including lower average educational attainment, lower incomes, and a higher proportion of minorities.¹¹² As such, it is important for stakeholders to monitor the intersection of health information and the internet as it develops.

Nearly one in three nonelderly adults enrolled in Medi-Cal had never used the internet (27.9%). Nonelderly adults with private insurance were most likely to have used the internet (93.6%).



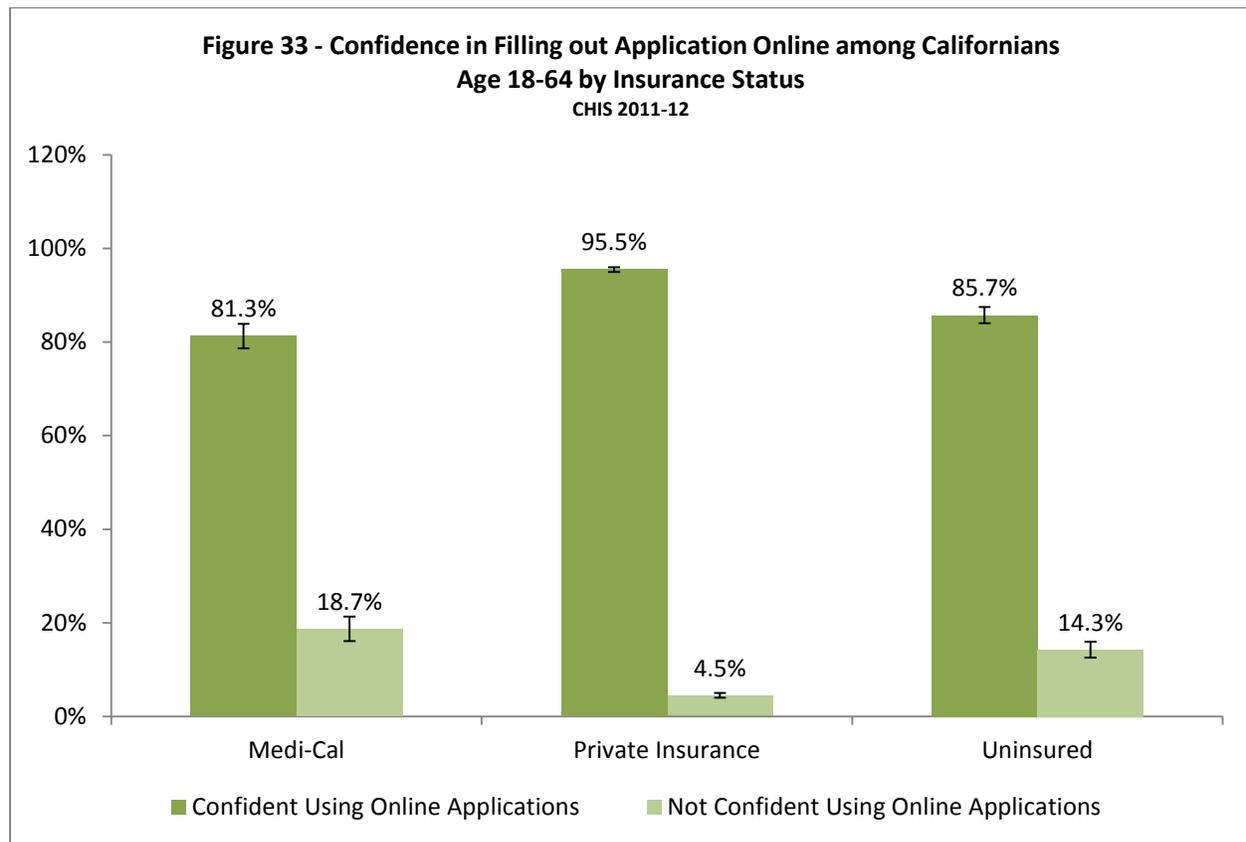
Findings: Comfort Level with Internet Applications in California’s Nonelderly Adult Population

CHIS Question: “How confident are you that you can fill out an application online?”

As discussed earlier in this report, populations less likely to have internet access share many traits with the Medi-Cal population, including lower average educational attainment, lower incomes, and a higher proportion of minorities.¹¹³ As such, it is important for stakeholders to monitor the intersection of health information and the internet as it develops. One specific area of concern is comfort level filling out an application online. As more health organizations and public programs move toward an electronic application process, it will be important to monitor populations who are not confident using the internet to ensure that they retain equal access to information and services.

CHIS interviewers only asked the above question to respondents who reported having used the internet. The proportions below reflect the percentage of people within those who have used the internet.

RASD’s findings for comfort using an internet application mirror findings reported earlier in this report for internet usage. Among nonelderly adults who use the internet, those with Medi-Cal (18.7%) and without insurance (14.3%) were more likely to lack confidence filling out an internet application when compared with nonelderly adults with private insurance (4.5%).



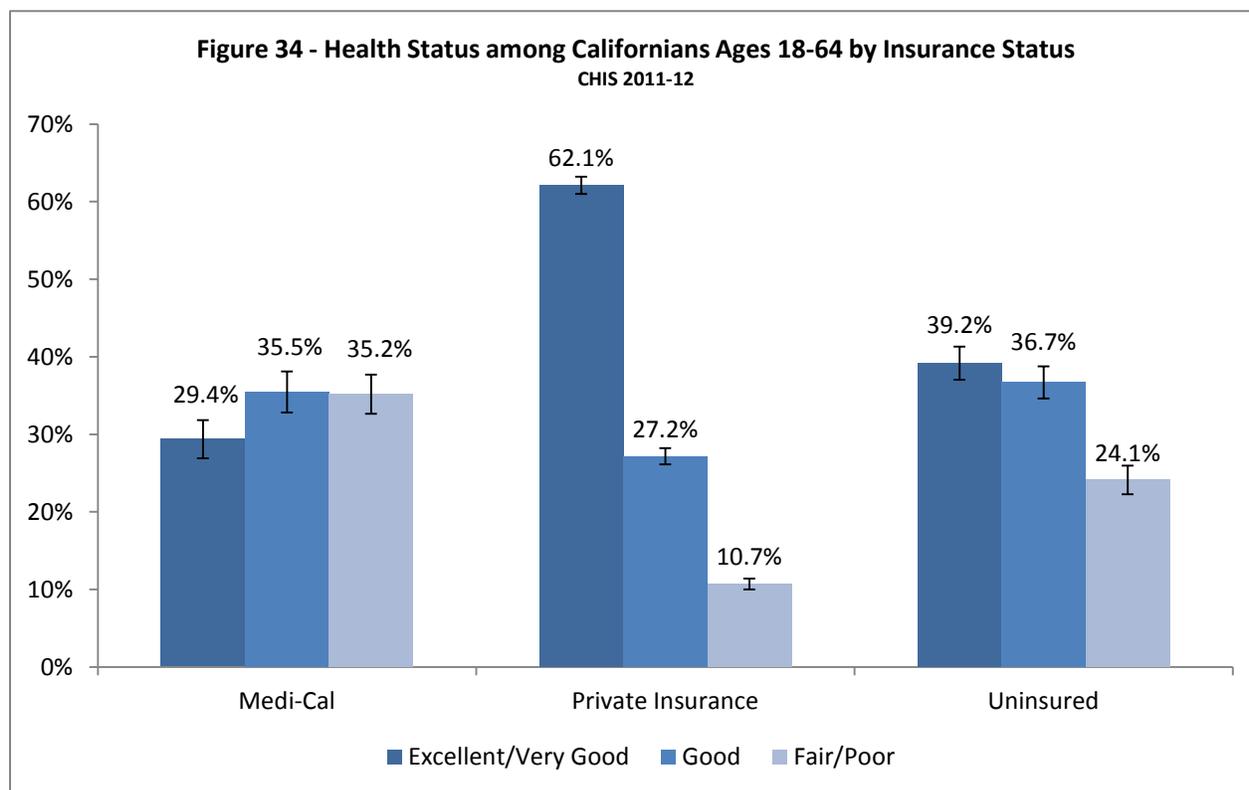
Findings: Self-Reported Health Status in California’s Nonelderly Adult Population

CHIS Question: “Would you say your health is excellent, very good, good, fair or poor?”

Self-reported health status is the measure of an individual’s perception of their own health status. This versatile measure allows researchers to compare health over time and between populations that may not have sufficient conditions in common to allow for other corresponding measures.¹¹⁴ Further, the literature demonstrates that self-reported health status contributes to predicting hospitalizations and mortality.¹¹⁵ The Healthy People organization recognized the importance of self-reported health status by incorporating the measure into their 2020 goals to improve the quality of life and well-being for all individuals.¹¹⁶

Self-reported health status strongly correlates with socioeconomic factors. A national study found that states with greater income inequality were 30% more likely to have individuals report fair or poor health than states with less pronounced income disparity.¹¹⁷

Nonelderly adults enrolled in Medi-Cal were three times more likely (35.2%) than adults with private insurance (10.7%) and 1.5 times more likely than the uninsured (24.1%) to report that their health was fair or poor. Nonelderly adults with private insurance were most likely to report excellent or very good health (62.1%).



Findings: Disability in California’s Nonelderly Adult Population

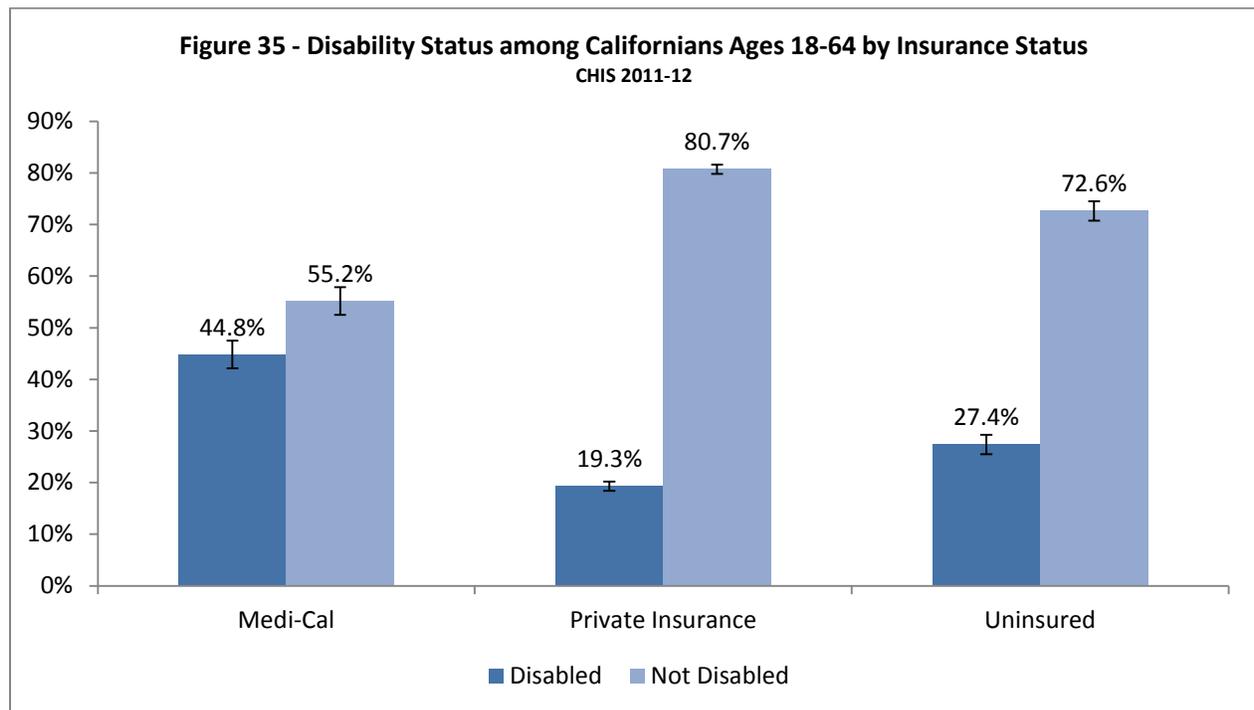
CHIS Question: “Are you blind or deaf or do you have a severe vision or hearing problem? Do you have a condition that substantially limits one or more physical activities such as walking, climbing stairs, reaching, lifting, or carrying? Because of a physical, mental, or emotional condition lasting 6 months or more do you have any of the following:

- Any difficulty learning, remembering, or concentrating?
- Any difficulty dressing, bathing, or getting around inside the home?
- Any difficulty going outside the home alone to shop or visit a doctor’s office?
- Any difficulty working at a job or business?”

Disabilities can cover a wide range of physical, emotional, and mental difficulties developed at any stage of life. A person’s likelihood of developing a disability increases with age; however, many disabilities can be delayed or prevented with healthy habits and increased access to care. In 2009, 20.9% of Californians 18 years of age or older had a disability.¹¹⁸

For the purpose of this analysis, RASD defined disability as answering yes to any of the CHIS survey questions listed above.

Almost half of the adults enrolled in Medi-Cal were disabled (44.8%). Nonelderly adults enrolled in Medi-Cal were twice as likely as nonelderly adults with private insurance (19.3%), and more than 1.5 times the proportion among adults with no insurance (27.4%) to have a disability.



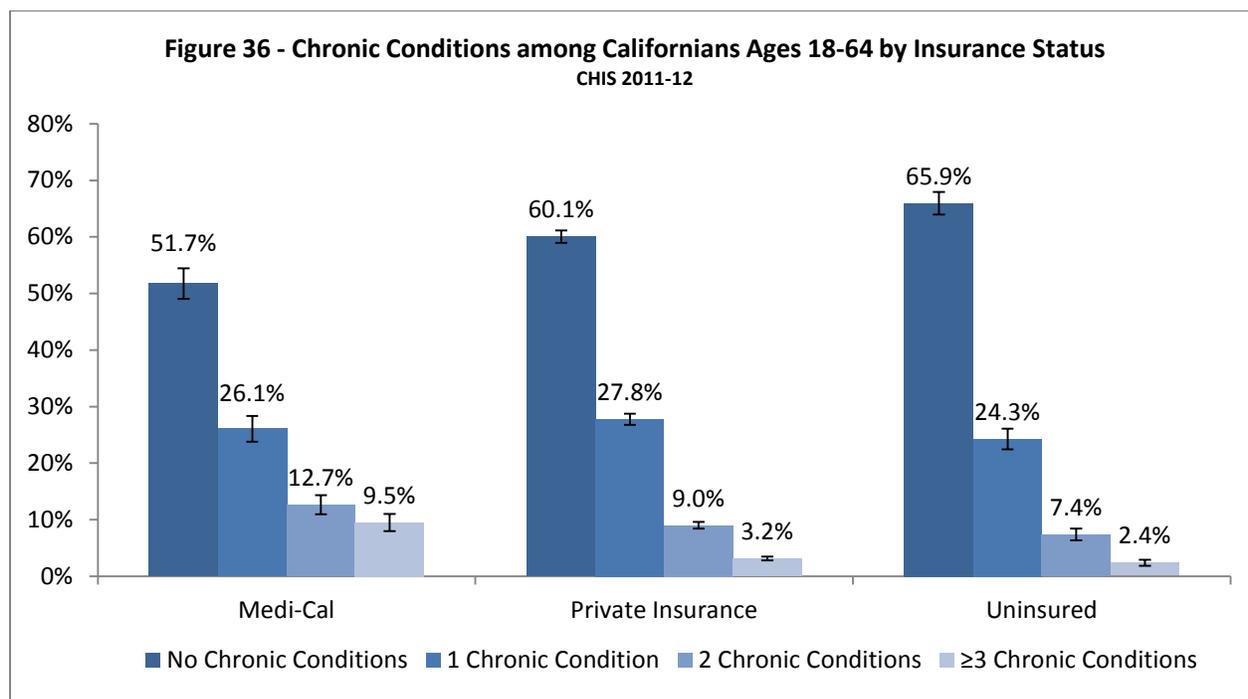
Findings: Chronic Conditions in Medi-Cal’s Nonelderly Adult Population

See Appendix A for the questions used to measure chronic conditions using CHIS data.

Chronic conditions are among the most costly and common health problems in the U.S. The Agency for Healthcare Research and Quality (AHRQ) defines a chronic condition as one which “lasts 12 months or longer and meets one or both of the following tests: a) it places limitations on self-care, independent living, and social interactions; b) it results in the need for ongoing intervention with medical products, services, and special equipment.”¹¹⁹ Many chronic conditions are preventable; healthy lifestyles and access to high-quality preventative measures help to reduce incidence, cost, and future disabilities due to chronic conditions.^{120,121} Lack of exercise, poor nutrition, tobacco use, and excessive alcohol consumption contribute notably to illness and pain related to chronic conditions.¹²²

Appendix A, Data Sources and Methods, gives a detailed description of the questions used to determine the number of conditions reported in this analysis.

Nonelderly adults enrolled in Medi-Cal had the highest rates of chronic disease diagnoses. Nonelderly adults with private insurance and no insurance were less likely to report two or more chronic illnesses (12.2% and 9.8%, respectively) than those with Medi-Cal (22.2%). Fully 60.1% of the privately insured and 65.9% of the uninsured reported no chronic conditions. However, it is possible that those with no insurance simply did not have an opportunity to visit a doctor and receive a chronic condition diagnosis.



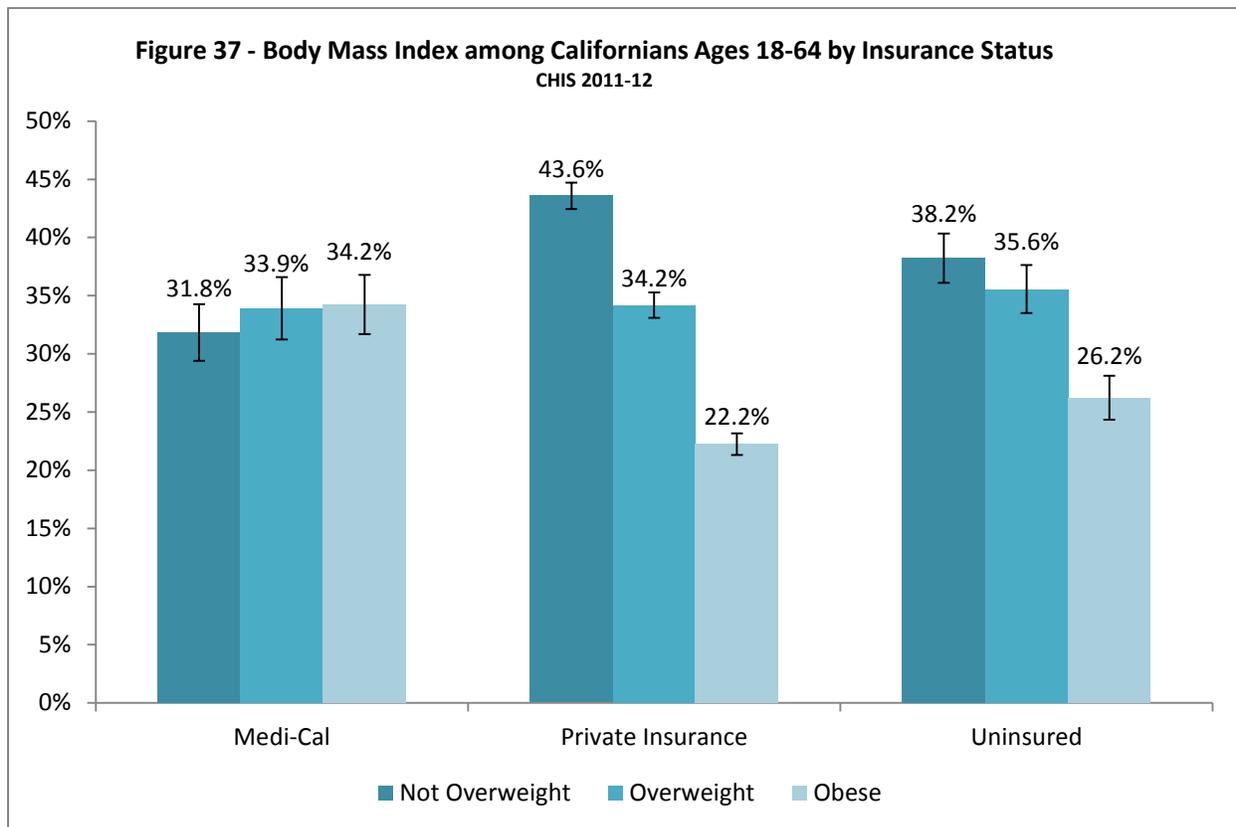
Findings: Obesity in California’s Nonelderly Adult Population

CHIS Question: “How tall are you without shoes? How much do you weigh without shoes?”

The prevalence of obesity in the U.S. has increased consistently in recent decades.¹²³ One common measurement of individual and population obesity is the BMI measurement. BMI uses a calculation of weight versus height to determine the ideal weight for an individual.¹²⁴ Although BMI measures for unhealthy body weight rather than body fat, research indicates that BMI correlates with levels of body fat and can function as a predictor of negative health outcomes.¹²⁵ Children with a high BMI have an increased probability of becoming obese adults, and obese adults are at greater risks for chronic conditions.¹²⁶ The increased prevalence of obesity has a significant impact on the incidence of adverse health outcomes such as cardiovascular disease, type 2 diabetes, cancer, osteoarthritis, work disability, and sleep apnea.¹²⁷

To calculate the BMI values for the study population, CHIS interviewers asked respondents their height and weight and performed the BMI calculation using those values. See [Appendix A, Data Sources and Methods](#), for a detailed description of the BMI calculation and the definition of overweight and obese.

The proportion of overweight and obese adults in the study population was highest among nonelderly adults enrolled in Medi-Cal (68.1%) and lowest among adults with private insurance (56.4%).



Findings: Pregnancy Status in California’s Nonelderly Adult Population

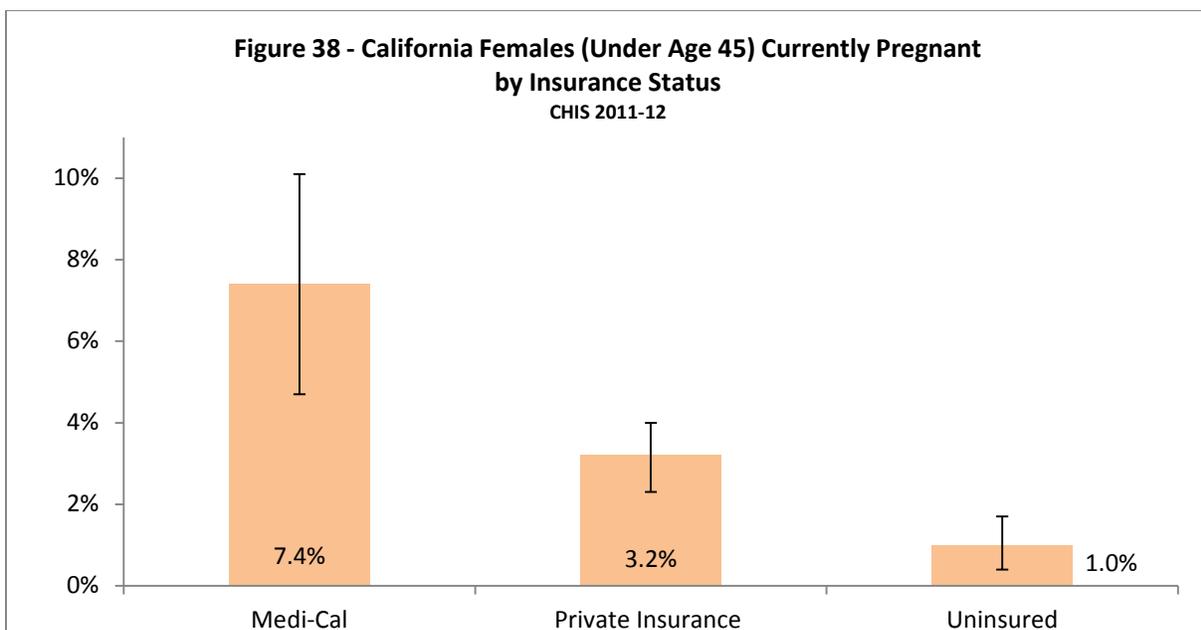
CHIS Question: “To your knowledge, are you now pregnant?”

The U.S. general fertility rate (GFR) in 2011 was 63.2 births per 1,000 women of childbearing age (ages 15-44), a 1.4% decline from 2010 (64.1 per 1,000 women of childbearing age).¹²⁸ In California, fertility rates decreased from 64.8 per 1,000 women of childbearing age in 2010 to 63.4 per 1,000 women of childbearing age in 2011.^{129,130} Although slightly higher than the national rate, the California GFR for 2011 represented a 2.2% decline from 2010.

In 2011, approximately 12% of all hospitalizations in the U.S. were for maternity care, and an additional 10% were for care of newborns.¹³¹ Live born (newborn infant) deliveries are the most common reason for hospital care in the U.S., and this trend holds true in the Medi-Cal program. Among female beneficiaries under ages 65, childbearing is the primary reason for seeking health care in the Medi-Cal program.¹³² In 2011, Medi-Cal financed a record 50.4% of hospital births to California residents.¹³³

Confirmed pregnancy constitutes an eligibility pathway for Medi-Cal enrollment. The relationship between pregnancy and Medi-Cal enrollment may explain the elevated proportion of pregnancies in the Medi-Cal population reported here. RASD advises readers to consider the correlation between pregnancy and Medi-Cal eligibility when drawing conclusions regarding the data below.

CHIS data shows that among women under 45 years old, Medi-Cal had the highest proportion of pregnant women at 7.4%. The proportion of Medi-Cal women who were pregnant was 131.3% higher than that of the privately insured women (3.2%) and over 600% higher than that of the uninsured (1.0%).



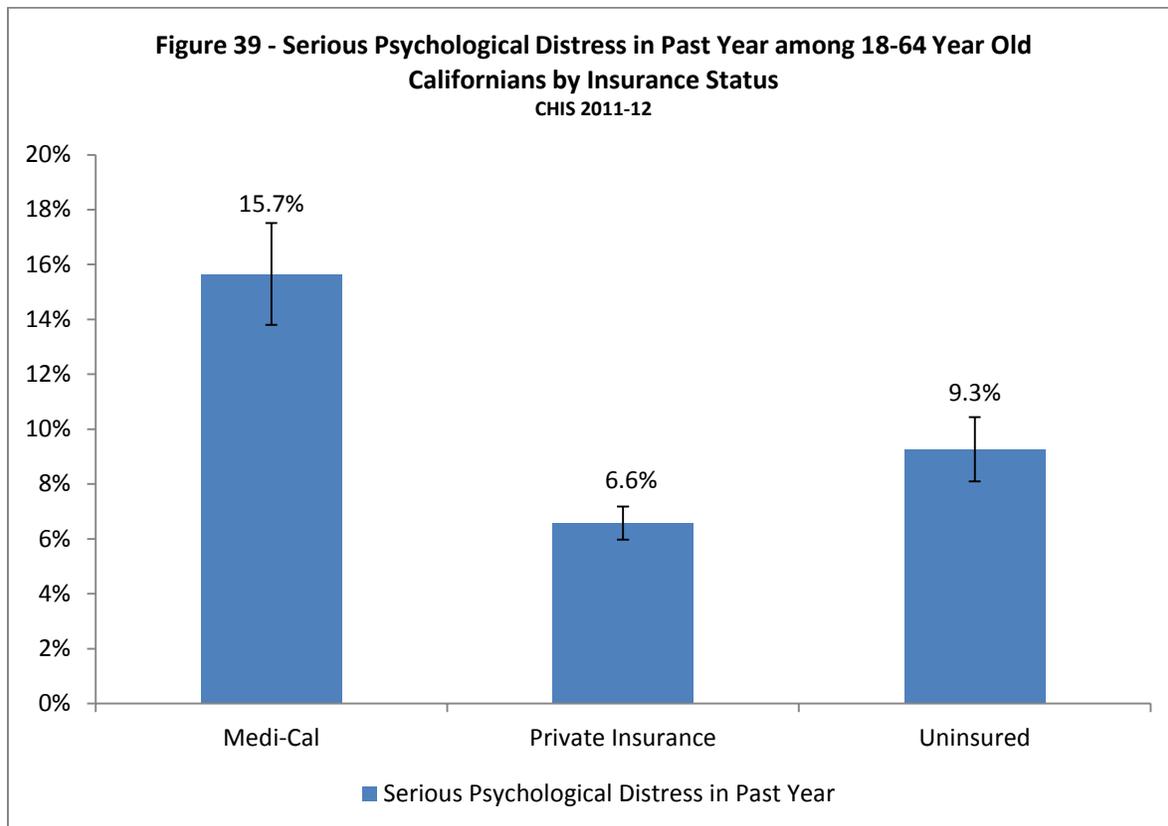
Findings: Serious Psychological Distress in Medi-Cal’s Nonelderly Adult Population

CHIS Question: “During the past 30 days how often did you feel nervous, hopeless, restless or fidgety, so depressed that nothing could cheer you up, everything was an effort, or worthless?”

Serious psychological distress (SPD) is a measure of nonspecific mental illness. Adults with SPD have similar characteristics to persons with serious mental illness as described in psychiatric epidemiological studies.¹³⁴ Research shows that adults with severe mental illness are more likely to be socially and economically disadvantaged, with lack of insurance as a barrier to care.¹³⁵ Many adults with SPD do not receive specialty care.¹³⁶ A study using the National Health Interview Survey found that SPD corresponded with increased mortality before and after controlling for socio-demographic factors, health behaviors and physical illness.¹³⁷

The SPD measures reported by CHIS are determined using the Kessler-6 (K6) scale. The K6 scale identifies persons with a high likelihood of having a diagnosable mental illness with as few questions as possible. [Appendix A](#) contains a detailed description of the method used by RASD to score these questions.

Nonelderly adults enrolled in Medi-Cal were more than twice as likely (15.7%) to have SPD as nonelderly adults with private insurance (6.6%), and more than 1.5 times more likely than adults with no insurance (9.3%).



More Information on the Medi-Cal Population

The Research and Analytic Studies Division (RASD) of the Department of Health Care Services (DHCS) performed the analysis for this report. RASD compiles official statistics and performs analytical studies to assist DHCS in achieving its mission and goals. More information regarding Medi-Cal enrollment, program expenditures, and other relevant topics is available at the RASD [website](#).

Subscribe to the RASD Mailing List

Click [here](#) to receive email notifications when new statistical content is added the RASD website. The RASD website is updated regularly with graphics, pivot tables and statistical briefs describing the Medi-Cal population, Medi-Cal enrollment trends, and other issues relevant to the Medi-Cal program and its stakeholders.

IF YOU PLAN TO CITE THIS PAPER IN A SUBSEQUENT WORK, WE SUGGEST THE FOLLOWING CITATION:

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PLEASE NOTE:

This document provides a brief summary of complex subjects and should be used only as an overview and general guide to the Medi-Cal program. The views expressed herein do not necessarily reflect the policies or legal positions of the California Health and Human Services Agency (CHHS) or the California Department of Health Care Services (DHCS). These summaries do not render any legal, accounting, or other professional advice, nor are they intended to explain fully all of the provisions or exclusions of the relevant laws, regulations, and rulings of the Medicare and Medicaid programs. Original sources of authority should be researched and utilized.

Appendix A: Data Sources and Methods

Data Sources

The California Health Interview Survey (CHIS)

The California Health Interview Survey (CHIS) is the largest health survey in the state of California. The UCLA Center for Health Policy Research conducts CHIS in collaboration with the California Department of Public Health, the Department of Health Care Services and the Public Health Institute. Collecting information for all age groups on health and health related issues, CHIS gives a detailed picture of the health and health care needs of California's large and diverse population. In 2011, CHIS transitioned to a continuous survey taking two years to complete a data cycle. CHIS has included households with only cell phones since 2007.

Using an independent multistage probability sample, CHIS provides a representative sample of the state's non-institutionalized population. CHIS also provides estimates for most individual counties, as well as estimates for major racial ethnic subgroups and some smaller ethnic subgroups. CHIS conducted the landline sample using a random digit dialing (RDD) method from 41 single county strata and three multi-county strata. For the cell phone sample, CHIS used a RDD sample from telephone numbers with cellular service stratified into 28 geographic strata using seven CHIS regions and telephone area codes. Approximately 20% of the interviews included in the 2011-12 survey occurred via cell phone. Interviews were conducted in five languages: English, Spanish, Chinese (Mandarin and Cantonese dialects), Vietnamese, and Korean.

The 2011-12 survey completed 42,935 adult interviews. The graphs and charts for this report reflect data from 27,370 interviews of nonelderly adults ages 18 to 64 who were not on Medicare.

Medi-Cal Administrative Data

RASD drew enrollment eligibility data from Medi-Cal Eligibility Data Systems (MEDS) January 2012, reflecting a 12-month reporting lag, for 3,048,350 non-elderly adults.

Methods

This section provides details on select measures reported by RASD in this analysis.

Language Assignment (Language Spoken, Administrative Data)

Language	Percentage	Language	Percentage
Unknown	3.8%	Lao	0.1%
ASL	0.0%	Mandarin	0.2%
Arabic	0.3%	Mien	0.1%
Armenian	0.9%	Other Chinese	0.0%
Cambodian	0.3%	Other Non-Eng.	0.5%
Cantonese	0.8%	Other Sign	0.0%
English	57.2%	Polish	0.0%
Farsi	0.2%	Portuguese	0.0%
French	0.0%	Russian	0.4%
Hebrew	0.0%	Samoan	0.0%
Hmong	0.4%	Spanish	32.4%
Ilocano	0.0%	Tagalog	0.2%
Italian	0.0%	Thai	0.0%
Japanese	0.0%	Turkish	0.0%
Korean	0.1%	Vietnamese	1.8%

Urban/Rural Distinction

Urban – Rural Counties Description	Counties
<p>Urban Counties Includes: Counties in metro areas with populations of 1 million or more; Counties in metro areas with populations of 250,000 to 1 million; and Counties in metros areas with populations smaller than 250,000.</p>	<p>Alameda, Contra Costa, El Dorado, Los Angeles, Marin, Orange, Placer, Riverside, Sacramento, San Benito, San Bernardino, San Diego, San Francisco, San Mateo, Santa Clara, Yolo, Fresno, Kern, Monterey, San Joaquin, Santa Barbara, Santa Cruz, Solano, Sonoma, Stanislaus, Tulare, Ventura, Butte, Imperial, Kings, Madera, Merced, Napa, San Luis Obispo, Shasta, Sutter, Yuba</p>
<p>Rural Counties Includes: Urban populations of 20,000 or more, adjacent to a metro area; Urban populations of 20,000 or more, not adjacent to a metro area; Urban population of 2,500 to 19,999, adjacent to a metro area; Urban population of 2,500 to 19,999, not adjacent to a metro area; Completely rural area or an urban population less than 2,500, adjacent to a metro area; and Completely rural area or an urban population less than 2,500, not adjacent to a metro area</p>	<p>Lake, Mendocino, Nevada, Tehama, Tuolumne, Humboldt, Amador, Calaveras, Colusa, Glenn, Lassen, Modoc, Del Norte, Inyo, Mono, Plumas, Siskiyou, Alpine, Mariposa, Sierra, Trinity</p>

Food Insecurity

RASD measured food insecurity using the following 6 questions which represent a validated scale derived from the U.S. Household Food Security questionnaire:

- “The food that I/we bought just didn't last, and I didn't have money to get more. Was that often true, sometimes true, or never true for you in the last 12 months?”
- “I/we couldn't afford to eat balanced meals. Was that often true, sometimes true, or never true for you in the last 12 months?”
- “Please tell me yes or no in the last 12 months, since (date 12 months ago), did you (or other adults in your household) ever cut the size of your meals or skip meals because there wasn't enough money for food?” “How often did this happen-almost every month, some months but not every month, or in only 1 or 2 months?”
- “In the last 12 months, did you ever eat less than you felt you should because there wasn't enough money to buy food?”
- “In the last 12 months, since (date 12 months ago), were you ever hungry but didn't eat because you couldn't afford enough food?”¹³⁸

Number of Chronic Conditions

RASD measured the number of chronic conditions present in the population by summing the number of yes responses to the following questions:

- “Has a doctor ever told you that you have asthma?”
- “Has a doctor ever told you that you have diabetes or sugar diabetes?”
- “Has a doctor ever told you that you have high blood pressure?”
- “Has a doctor ever told you that you have any kind of heart disease?”
- “Has a doctor ever told you that you had a stroke?”
- “Has a doctor ever told you that you have some form of arthritis, gout, lupus or fibromyalgia?”

Body Mass Index (BMI) and definition of BMI and overweight

RASD measured the obesity and overweight status of the population using a Body Mass Index (BMI) calculation. BMI is a uniform comparative value based on a person's height and weight. The BMI equation is as follows:
$$[703 \times \textit{Weight (lbs.)}] \div [\textit{Height (in.)}]^2$$

RASD considered interviewees with BMI values of less than 25 as not overweight, interviewees with BMI values of 25 to less than 30 as overweight, and interviewees with BMI values of 30 or greater as obese.

Serious Psychological Distress

RASD measured serious psychological distress (SPD) using the Kessler-6 (K6 scale). First, respondents were asked the following six questions:

- How often during the past 30 days did you feel nervous?
- How often during the past 30 days did you feel hopeless?
- How often during the past 30 days did you feel restless or fidgety?
- How often during the past 30 days did you feel nothing could cheer you up?
- How often during the past 30 days did you feel everything was an effort?
- How often during the past 30 days did you feel worthless?

Possible responses to each of the six questions were all of the time, most, some, a little or none of the time. After these six questions, interviewers asked respondents:

- “Was there ever a month in the past 12 months when these feelings occurred more often than they did in the past 30 days?”

If respondents answered yes to this question, interviewers asked them the above six questions again about that worst month. Serious psychological distress in the past year was measured using the respondent's answers for the worst month in the past year. (Note: if respondents did not have a month when their feelings occurred more often than in the past 30 days, their score reflected their responses for the past 30 days.)

Each of the six question were scored from 0 to 4 based on the frequency of the symptom where none was equal to 0, a little was equal to 1, some was equal to 2, most was equal to 3, and all the time was equal to 4. A total score ranging from 0 to 24 was calculated by summing the scores for each of the questions. A respondent with a total score greater or equal to 13 was defined as having serious psychological distress.

Appendix B: Detail Data for California Maps (Figures 8 & 13)

Figure 8 – Percentage of Nonelderly Adults Enrolled in Medi-Cal by County

Counties	Percentage of non-elderly adults enrolled in Medi-Cal	Counties	Percentage of non-elderly adults enrolled in Medi-Cal
ALAMEDA	10.5%	ORANGE	8.6%
ALPINE	13.2%	PLACER	6.4%
AMADOR	9.3%	PLUMAS	12.9%
BUTTE	18.2%	RIVERSIDE	11.4%
CALAVERAS	12.2%	SACRAMENTO	15.8%
COLUSA	14.3%	SAN BENITO	12.0%
CONTRA COSTA	9.1%	SAN BERNARDINO	14.7%
DEL NORTE	22.5%	SAN DIEGO	8.3%
EL DORADO	7.9%	SAN FRANCISCO	9.8%
FRESNO	23.1%	SAN JOAQUIN	18.6%
GLENN	18.1%	SAN LUIS OBISPO	8.3%
HUMBOLDT	15.7%	SAN MATEO	6.2%
IMPERIAL	21.9%	SANTA BARBARA	12.0%
INYO	14.3%	SANTA CLARA	8.7%
KERN	18.9%	SANTA CRUZ	10.3%
KINGS	14.9%	SHASTA	19.1%
LAKE	23.0%	SIERRA	13.0%
LASSEN	9.6%	SISKIYOU	19.7%
LOS ANGELES	15.0%	SOLANO	11.4%
MADERA	20.7%	SONOMA	8.7%
MARIN	6.9%	STANISLAUS	18.5%
MARIPOSA	11.9%	SUTTER	17.2%
MENDOCINO	19.7%	TEHAMA	21.4%
MERCED	23.2%	TRINITY	17.4%
MODOC	18.0%	TULARE	26.7%
MONO	5.2%	TUOLUMNE	11.9%
MONTEREY	15.0%	VENTURA	9.1%
NAPA	8.5%	YOLO	9.6%
NEVADA	9.4%	YUBA	21.5%

Figure 13 – Percentage of Beneficiaries with Primary Language Other than English

Counties	English	All Other Languages	Counties	English	All Other Languages
ALAMEDA	60.8%	39.2%	ORANGE	45.6%	54.4%
ALPINE	96.1%	3.9%	PLACER	81.9%	18.1%
AMADOR	91.3%	8.7%	PLUMAS	91.5%	8.5%
BUTTE	83.2%	16.8%	RIVERSIDE	66.9%	33.1%
CALAVERAS	90.8%	9.2%	SACRAMENTO	68.8%	31.2%
COLUSA	53.3%	46.7%	SAN BENITO	60.0%	40.0%
CONTRA COSTA	65.3%	34.7%	SAN BERNARDINO	71.7%	28.3%
DEL NORTE	87.6%	12.4%	SAN DIEGO	58.7%	41.3%
EL DORADO	83.2%	16.8%	SAN FRANCISCO	50.0%	50.0%
FRESNO	59.7%	40.3%	SAN JOAQUIN	67.6%	32.4%
GLENN	68.3%	31.7%	SAN LUIS OBISPO	74.0%	26.0%
HUMBOLDT	89.9%	10.1%	SAN MATEO	50.7%	49.3%
IMPERIAL	43.3%	56.7%	SANTA BARBARA	48.7%	51.3%
INYO	77.6%	22.4%	SANTA CLARA	45.0%	55.0%
KERN	64.2%	35.8%	SANTA CRUZ	53.1%	46.9%
KINGS	66.0%	34.0%	SHASTA	91.9%	8.1%
LAKE	88.3%	11.7%	SIERRA	92.5%	7.5%
LASSEN	91.7%	8.3%	SISKIYOU	89.8%	10.2%
LOS ANGELES	47.2%	52.8%	SOLANO	72.9%	27.1%
MADERA	50.3%	49.7%	SONOMA	66.0%	34.0%
MARIN	49.3%	50.7%	STANISLAUS	67.8%	32.2%
MARIPOSA	91.9%	8.1%	SUTTER	69.4%	30.6%
MENDOCINO	78.1%	21.9%	TEHAMA	81.1%	18.9%
MERCED	59.5%	40.5%	TRINITY	93.1%	6.9%
MODOC	88.1%	11.9%	TULARE	57.8%	42.2%
MONO	60.3%	39.7%	TUOLUMNE	92.6%	7.4%
MONTEREY	40.5%	59.5%	VENTURA	51.2%	48.8%
NAPA	55.3%	44.7%	YOLO	60.8%	39.2%
NEVADA	88.8%	11.2%	YUBA	79.6%	20.4%

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