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**Focus Groups Findings from Non-Offering  
Latino and Vietnamese Small Employers and  
Low-wage Employees in Orange County**

**FINAL REPORT**

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## **EXECUTIVE SUMMARY**

This report summarizes key findings from a series of focus groups held with Latino and Vietnamese-owned small firms employing a majority of low-wage workers and with uninsured low-wage Latino and Vietnamese employees of small firms. CalOptima, the county organized health system in Orange County, commissioned this report to inform their pre-implementation activities under a grant from the Community Access Program of the U.S. Health Resources and Services Administration. The Institute for Health Policy Solutions and its subcontractors conducted this research with the goal of providing insight on ethnic small employers' and employees' experience with health insurance coverage and to detail their responses to various components of a "Working for Health" initiative to expand coverage to uninsured, low-income workers of small employers. The proposed "Working for Health" (WFH) initiative is a subsidized health insurance program targeted to low-income employees of small businesses.<sup>1</sup> The study was designed to probe their reactions to several program dimensions such as covered benefits, employer and employee contribution levels, provider networks, benefits equity, program administration, and marketing/promotion strategies.

Overall, the participating employers and employees reacted favorably to the WFH program. They found that the affordability and choice of providers proposed through the Working for Health program had substantial appeal relative to what they had either experienced in terms of employment-based or public coverage, or what they know is available to them in the private individual market. Furthermore, it was clear that those employers with private individual coverage were interested in the program as a potential source of coverage for their own families. There were no employers or employees that disapproved of the WFH program. While a few of the employee participants expressed some reluctance in joining the program, it was not because the program described was structurally deficient. Rather, these employees were mostly single and under the age of 25, and wanted to maximize their earnings rather than pay extra for health coverage that they did not feel they needed. Other research points to this particular demographic as the most difficult to reach because they generally do not perceive the need for health insurance coverage.<sup>2</sup> The majority of employees and employers, including those employers who had health coverage for themselves, were eager to get more information on the WFH program and expressed their desire to join as soon as it becomes available.

On the specific program dimensions, it was found that most employers and employees had a limited exposure and understanding of CalOptima as their local Medicaid managed care plan (and as an option under Healthy Families). They were much more familiar with specific hospitals and medical facilities that participate in the CalOptima network, and were more inclined to regard the provider network positively when specific providers were

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<sup>1</sup> Small employers are defined as having at least two and no more than 50 employees. For purposes of this research project, low-wage workers are defined as earning \$12.00 an hour or less. This \$12/hour threshold was chosen as a proxy for low-income individuals in Orange County, California.

<sup>2</sup> California HealthCare Foundation. *To Buy or Not to Buy: A Profile of California's Non-Poor Uninsured*. Oakland, CA. April 2000.

identified. Some of the employers expressed interest in having a choice of health plans, including Blue Cross and Kaiser, for themselves and their higher wage employees who might be required to contribute more to participate in the program. A few indicated that they already had coverage through one of these plans, and wanted to have the option of either retaining their coverage or switching to another plan. Other employers simply wanted a choice of plans, as choice seemed to be more of a concern from the employer perspective. Overall, employers tended to raise questions about their choice of health plans, while employees were more concerned about the proposed benefit plan.

Nearly all the employees thought that coverage for hospitalization and pharmacy benefits were essential to the overall benefit package. Several uninsured employees were also very concerned that dental and vision benefits may not be considered as part of the benefit plan, and were willing to pay an additional premium to have access to dental and vision coverage.

Employees and employers were equally interested in how much they would be expected to contribute towards a comprehensive benefit plan with some choice of providers. There was greater consensus among the employers about what constituted an “affordable” employer contribution. Most employers indicated that they could contribute approximately \$50 per employee per month for single coverage, with some willing to pay up to \$100 per month for family coverage. However, a subset of those employers indicating a threshold of \$50 per employee per month were less willing to contribute much more for those employees who elect to receive family coverage.

Employee responses tended to vary more in what they were willing to contribute towards their monthly premium. On the low end, employees said they could afford \$20 per month and, on the high end, up to \$50 a month for single coverage. Of those employees interested in family coverage, the amount that they indicated they were willing to pay spanned between \$80 and \$150 per month per family. However, because the focus group selection criteria were based on wage level and not family income, some of the participants with higher family incomes were likely the ones who said they could afford the high end (\$100-\$150 per month) of the range. Given that the average wage level for the employee participants was \$10 per hour, premium levels of \$100 a month or \$1,200 annually are going to be difficult for most of these employees to afford.

There was general consensus among employers and employees that it would be acceptable for the program to offer a scaled down benefit package to childless workers in order to facilitate their participation (assuming a subsidy would not be available for these workers). Further research may be required to probe their receptivity towards specific components of a scaled-down benefit design, such as a more limited choice of providers, reduced benefits or higher copayments.

Specific ethnic differences emerged with respect to employer/employee working relationships and perceptions of government-sponsored programs. In general, the Vietnamese employer and employee working relationship seemed to be largely based on economics, and several workers said they would jeopardize their jobs in asking for benefits beyond an

hourly wage. The Vietnamese employees voiced deep concerns in approaching their employers about a new program, even though it may be affordable and beneficial from the employer's perspective. The dynamics in this community seemed to be more heavily weighted towards employer control.

In contrast, Latino employees expressed a more open, and in some cases, familial working relationship with their employers. The Latino employees did not express any concerns in presenting the WFH program to their employers, and said that their employers felt a responsibility towards them to provide health benefits and yet were prohibited because the costs are too high.

Not surprisingly, Latino employers and employees posed many questions about the WFH program and whether it is a public or private program. Latino employers in particular voiced extreme caution in creating a program that would require applicants to provide information on their immigration status. Employers did not want to place themselves or their workers at risk for additional scrutiny by the government, which they perceive as unreasonably intrusive towards immigrants in the wake of the September 11<sup>th</sup> terrorist attacks. Because they had mostly negative perceptions of government-sponsored programs, Latino employees were likewise reluctant to enroll in a program that appears to be "government run" or that would ask questions about their immigration status. This was not the case with the Vietnamese employees, whose immigration experience in the United States and perception of public programs in general was more positive compared to their Latino counterparts.

## **INTRODUCTION**

As part of its HRSA Community Access Program grant, CalOptima contracted with the Institute for Health Policy Solutions (IHPS) to conduct focus groups with Latino and Vietnamese-owned small firms that do not offer health insurance coverage and with uninsured, low-wage employees of small firms. This research provides insight on small employers' and employees' experience with health insurance coverage and summarizes their responses to a proposed "Working for Health" initiative to expand coverage to uninsured, low-wage workers of small employers (See Appendix A).

CalOptima and its partners are in the planning phase of a job-based initiative to provide affordable health insurance to small employers and their workers in Orange County. These focus groups were designed to test various approaches to a "Working for Health" program and solicit feedback from employers and employees on several components of the program. These components included employer and employee contribution levels, provider networks, participation levels (full-time vs. part-time), benefit plans, administration and marketing/communication strategies.

This report is based on eight focus groups with small employers and uninsured low-wage employees in Orange County, California. Four focus groups were held with non-offering small employers and four were with full and part-time low-wage workers. The Vietnamese and Latino employees were uninsured and all worked for small employers that do not offer health insurance coverage. Participating employers were Vietnamese or Latino small business owners or managers who do not offer coverage to their low-wage employees.

The focus groups were conducted in Costa Mesa, California between March and May 2002. This summary report includes direct quotations from the employers and employees to minimize potential errors in the interpretation of what was said or meant. Quotation marks are used whenever the exact words used by an employer or employee are cited, and in some cases, missing text was inferred from the speaker and bracketed for clarification purposes. For confidentiality reasons, only a generic description of the speaker is provided after each quotation.

The findings presented in this report are based on descriptive research from focus group discussions. While this mode of research can assist in identifying themes and variations among the groups studied, the findings should not be interpreted as representative of what all employers or employees in Orange County think about health insurance or potential coverage options.

## **STUDY METHODOLOGY**

The employer focus groups were conducted to examine small employers' reactions to a hypothetical "Working for Health" program approach and to test the types of program components that may improve Latino and Vietnamese-owned small employers' health coverage offer rate to their employees. The employee focus groups sought to obtain

feedback from uninsured low-wage employees on their receptivity to take up the proposed coverage through the "Working for Health" program.

Forty-four non-offering employers participated in four focus groups held on March 26 and 27 and May 9, 2002 in Costa Mesa, California. Two of these focus groups were held in Vietnamese and two in Spanish. The participants in the employer groups represented businesses in a wide range of industries, including auto repair, janitorial, construction and machinery, beauty salons, dry cleaning, food and beverage, retail, travel, interpretation services, and legal and accounting services. The participating employers had an average of 4.1 workers (with a range between 2 and 14 workers) and had been in business an average of 7.3 years. Nine (20%) of the participating firm owners were themselves uninsured.

Four focus groups, two in Vietnamese and two in Spanish, were held with 40 uninsured low-wage employees of small businesses on May 8 and 9, 2002 in Costa Mesa, California. Employees worked for businesses in a wide range of industries including janitorial and construction services, electronics, painting, printing services, retail, food and beverage, beauty salons, and medical offices. These participants were employed an average of 3.2 years (with a range of 6 months to 8 years with their current employer) and worked at firms with an average staff size of 11.6 workers). Sixty-three percent were married and 68% had children. All participants were full-time employees. Participants in the employee groups represented a range of ages from 18 to 64.

Lake Snell Perry and Associates and Atkins Research Group, Inc., were retained to assist in participant screening and recruitment. Atkins Research sought participants using three databases: one generated through outreach conducted by CalOptima, the second from the Orange County Congregation of Church Organizations (OCCCO), and a third from Atkins Research. Recruiters used a screening questionnaire developed by IHPS to ensure that participants met the recruitment criteria. IHPS developed the moderator's guide and retained two professional, bilingual moderators to facilitate the focus groups, translate the discussions, and transcribe the audiotapes. Simultaneous interpretation of each of the groups was also provided by bilingual staff from CalOptima to assist the research team in the analysis and compilation of findings included in this report.

Eligible participants in the employer groups met the following criteria: employed between 2 and 50 full-time or permanent part-time workers in a firm located in Orange County, did not offer health insurance coverage to any employee, employed at least 50% of workers earning \$12 per hour or less and had a workforce that was at least 50% Latino and/or Vietnamese.<sup>3</sup>

Participants in the employee focus groups met similar criteria: uninsured full-time or permanent part-time worker in a small firm located in Orange County that did not offer health insurance coverage, earned no more than \$12 per hour, and of Latino or Vietnamese ethnicity.

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<sup>3</sup> Focus group selection criteria included employee wage level and not family income. However, employee eligibility for a subsidy in the "Working for Health" program would be based on family income, rather than wage level.

Each group was audiotaped for later review and translation purposes. The audiotapes were then back-translated into English and reviewed by the moderators for accuracy. Finally, the tapes were transcribed into documents for review and analysis by the research team.

## **LIMITATIONS**

It should be noted that the findings presented in this report are based on qualitative focus group research. Although qualitative research can provide key information, identify trends, and generate hypotheses useful for further research, these findings are not necessarily generalizable to the larger population of small employers or employees in Orange County.

There is also the potential for some selection bias beyond that which may typically occur in focus groups with small employers. In the case of non-offering employers, although they were provided a nominal financial incentive to participate in the discussions, these employers had enough interest in the topic to take time out of their usual schedules to attend the focus groups. Moreover, participating non-offering firms may be more anomalous because many other non-offering small employers may be unwilling to participate in a discussion of health insurance due to their sensitivities about offering employee benefits or potentially raising employee expectations through their participation.

## **KEY FINDINGS**

This section presents the results of the focus groups with Orange County Latino and Vietnamese-owned small employers and low-wage Latino and Vietnamese employees of small businesses that do not offer health coverage. The mode of analysis was primarily descriptive and focused on questions contained in the moderators' guides.

### **SMALL EMPLOYERS' EXPERIENCE WITH HEALTH COVERAGE**

- Of the 44 small firms that do not offer health insurance coverage to their employees, 35 of the firm owners or managers (24 in Vietnamese groups and 11 in Latino groups according to transcripts) currently had health insurance coverage for themselves and their family members. Of these 35 insured owners, over half received coverage through a spouse. The remaining insured employers purchased individual coverage through Kaiser, Blue Cross or a private insurance carrier. Employers were acutely aware of the need and importance of having health insurance.

*“You don't know when an accident will happen or when you will get sick so we need insurance to protect our lives.” – Vietnamese employer*

*“I think it's very important because I have had two accidents and without insurance I would have to go to the emergency room. It's very important for me to have it for my children. You know how they get sick all the time.” - Latino employer*

- Most of the non-offering employers noted that their knowledge of their employees' insurance coverage was limited. A few employers indicated that they knew employees tended to seek care at community health clinics and that in some cases their children have coverage through the Healthy Families program<sup>4</sup>.
- Most non-offering employers indicated that they would like to provide coverage to all of their employees, regardless of wage level, family coverage status or work status (full-time and part-time). Those employers interested in providing coverage said that the additional benefits would make employees happier and more productive on the job. The one exception was those employers with predominately contract employees, such as beauty salon owners, who responded that it was not realistic to provide coverage to their staff.
- Most of the employers and their family members seek care within Orange County. The few who indicated that they travel out of county or across the border for health services indicated that they did so occasionally for medications, as prescription costs are significantly lower in Mexico as compared to the United States. However, due to the amount of time and resources required to travel to neighboring countries to seek care, nearly all of the participants said that they prefer to receive care from Orange County providers.

## **PRIMARY REASONS SMALL EMPLOYERS DO NOT OFFER COVERAGE TO THEIR EMPLOYEES**

- The most common reason employers cited for not offering coverage was the high cost of health insurance and their inability to contribute towards adequate coverage. Many expressed frustration at the lack of affordable options for themselves and their employees. Both the Latino and Vietnamese small employers said repeatedly that their businesses had such slim profit margins that they could not afford paying one-third to one-half of premiums in order to make it affordable for their employees.

*“I did look around and find out the price, but it is too high. So I cannot afford to buy health insurance for my employees because I would not make enough profit to be able to buy it for them. But then I don't like to tell employees that they have to buy it because I don't think they can afford it.” – Vietnamese employer*

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<sup>4</sup> Healthy Families is state's SCHIP program that provides medical, dental and vision coverage to children ages 0 to 19 in families with incomes between 100% and 250% of the federal poverty level. To qualify for the Healthy Families program, the applicant must not be eligible for no-cost Medi-Cal or job-based coverage and be a U.S. citizen or have legal immigrant status.

*“It’s because my business is very small and the revenue we bring in is very small. I did think about it and I did shop around. And I am still shopping around.”*

*– Latino employer*

*“I used to be able to afford insurance. Now I think that sometimes not even the rich can pay for it.” – Latino employer*

- These non-offering employers cited several other interrelated reasons for not offering health coverage to their employees such as limited choice of providers, their perception of receiving “bad” service in the past, or that they have high employee turnover. Several employers said the costs had become so prohibitive that they were having problems paying just for their own coverage.

*“The service they provide is not first class. It’s third class and when they use the insurance they just look them over and say they are fine, even if they are not. They don’t provide the type of service they should.” - Latino employer*

Of those employers who knew about some of their employees’ coverage status, a few indicated that their workers had private coverage or coverage through a spouse. In most cases, however, the employee was uninsured and if their dependents had coverage, it was through Medi-Cal, Healthy Families or the California Kids programs<sup>5</sup>.

A number of the employers, particularly the Latino-owned firms, felt that it was their responsibility as employers to provide health insurance to their employees. In the Vietnamese groups, there tended to be more of a mixed sense of responsibility as employers to provide coverage to their workers. Some of the very small employers said that to provide a wage was sufficient, and that to provide benefits in addition to workers’ compensation was beyond their responsibility as a small business owner.

*“I don’t think that what the company will be able to produce is as important as a person’s health. I think it’s important for the employee who stays with me for one or two years to be in good health...I think paying for insurance allows the person to feel more at ease to get a check-up even if they don’t feel bad.” – Latino employer*

*“For me I don’t think [getting insurance for my employees] is very important because we pay their salaries. We just deal with them and say ‘this is how much we pay you.’ I know about my shop and other shops. You know how much you pay but you don’t worry about the health insurance.” - Vietnamese employer*

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<sup>5</sup> The California Kids program is a private sector initiative that provides preventive and primary care coverage to children ages 2 to 18 in families with incomes less than 250% FPL who are not eligible for Healthy Families or full-scope Medi-Cal. The CalKids program is available to income-eligible children regardless of immigration status; however, enrollment is often capped on a county-by-county basis.

Two Vietnamese employers said that they would likely have to reduce employee wages in exchange for their offering health insurance, and that this could jeopardize their ability to retain employees.

*“For my company, it is very small. I just think that it’s better to pay [my employees] a higher salary. I think they’re more willing to stay than if I paid them a low salary. As for [providing] health insurance, I don’t think it would help to keep them with me. So I don’t even think about offering that.”*

*- Vietnamese employer*

## **WHERE EMPLOYERS THINK THEIR EMPLOYEES WOULD PREFER TO RECEIVE COVERAGE**

- A majority of the employers indicated that their employees would prefer to receive some form of health coverage through the workplace rather than on their own or from the government. This preference was more pronounced in the Latino employer groups, where the participants expressed deep reservations about their workers being comfortable applying for a government program. Several said that the scrutiny of immigrants post-September 11<sup>th</sup> had really escalated their employees’ fear and suspicion of any program affiliated with the government. This seemed to be a general impression that applied to all of their workers, though employers thought it was more likely that the program would be viewed suspiciously by workers who themselves may be undocumented or who had family members with questionable legal status. Latino employers were also conscious of the difficult position they would be placed in if the program asked about applicants’ immigration status.

*“If the application has those questions asking for Social Security and legal status then the employer could feel wary. I would because the funds are coming from the government.”*

*– Latino employer*

*“If it concerns the government in general, maybe the employees will not want to give that information because they might feel they are turning themselves in.”*

*– Latino employer*

*“People will not apply if you ask about their legal status. They are scared because of things right now.”*

*– Latino employer*

Some of the Vietnamese employers that indicated a preference for job-based coverage said that it would likely be less expensive for their employees than if they had to purchase it in the individual market. They were concerned about their employees who were single or married without children, and who had no other affordable options for health coverage.

- A few employers said that their lower-wage workers may prefer to enroll their children in the Healthy Families program if the monthly premium and copayments under the new program were significantly more than those offered through the HFP.

## **POTENTIAL BENEFITS FOR EMPLOYERS IN PROVIDING AFFORDABLE COVERAGE TO THEIR EMPLOYEES**

- Employers were fairly aware of the advantages in providing health benefits to their workers. Several said that their employees would be happier and others added that they would also be more productive on the job and less likely to miss work because of illness. A few employers went on to say that they would be able to keep their employees for a longer period of time.

*“I think that health insurance is important because you can make the employees happy. When the employee is healthy then he can go to work.”*

*– Vietnamese employer*

*“If there is an opportunity for us to provide health insurance for our employees, we will be able to keep our employees longer, especially the good employees. So we would feel proud that we have employees that have insurance working with us, and also when they are in good health they can contribute more to the company.”*

*– Latino employer*

- The participating non-offering employers did not think the additional paperwork and administration would be much of a burden or prohibit them from enrolling in the new program. Most had either a bookkeeper or accountant that could assume the responsibility of collecting the paperwork and calculating payroll deductions according to program requirements.

## **EMPLOYEES’ EXPERIENCE WITH HEALTH COVERAGE**

- Uninsured low-wage employees recognize the need for and importance of having health insurance, and understand the extent to which their access to care is limited without insurance. This recognition was greater for older employees and employees with dependents.

*“Any accident, illness or hospital visit without insurance is a great burden. Hospitals have gotten to the point where if a person doesn’t have insurance that person will not receive medical care. It’s frightening – you just pray to not get sick or have an accident.”*

*– Latino employee*

*“When you don’t have health insurance when you go to the doctor I don’t think they take as good care of you as if you have health insurance. People with insurance are more welcome than those who don’t at the doctor’s office.”*

*– Vietnamese employee*

*“I worry most for my daughter because she has been sick. I always worry about us getting sick and then you go to the doctor and they clean you out [financially].”*

*–Latino employee*

- When uninsured employees were able to seek care, they generally had a positive experience with community clinics in Orange County. What they found most appealing about their clinic experience was that they were able to interact with providers who could understand and speak their language. They were very concerned, however, about the lack of choice in providers under prior insurance arrangements.

*“I have been treated very well at the clinic. I had a female problem and they sent me to a good surgeon. They even sent an interpreter.” – Latino employee*

## **WHERE EMPLOYEES WOULD PREFER TO RECEIVE COVERAGE**

- Small business employees were fairly knowledgeable of their options and the pricing of health insurance premiums in the marketplace. They had experience researching and pricing individual policies and knew which were the most affordable plans offered in Southern California. Due to high costs and the administrative hassle, low-wage uninsured employees indicated a preference for receiving coverage through their employer if they could have some choice of providers and an affordable premium relative to purchasing coverage on their own in the private market.

*“If we had health coverage through our work, suppose you don’t feel well or if you cut your finger, you go to the doctor with peace of mind because you know you are covered.”*

*– Latino employee*

- There were very different perceptions of government coverage by ethnic group. The Latino employees were extremely reluctant to enter a program that is in any way connected to government.

*“I prefer when my company pays. Sometimes when it’s from the government they treat you however they want and they feel they are giving you something for free.”*

*– Latino employee*

However, more of the Vietnamese participants felt that government coverage was more stable than coverage either on their own or through their employer.

*“I think through the government is best. Through the government you are not afraid of being laid off. You only pay so much for government [coverage] and you will be covered.”*

*– Vietnamese employee*

*“ Because government insurance can cover more and if something happens to you then the government insurance takes care of you.”*

*– Vietnamese employee*

## **EMPLOYEES’ RELATIONSHIP WITH THEIR EMPLOYER**

- Ethnic differences were notable in the groups’ perceptions of employer responsibility to offer health coverage. Latino employees said that it is the responsibility of their employer to provide health benefits to their employees, perhaps due to more familiar relations with their employer/business owner. The Vietnamese employees’ reactions were more mixed. Some felt it was their employer’s responsibility to provide coverage in addition to wages; however, most were wary of extending this responsibility to their employer due to their concerns about job security.
- Employees had markedly different relationships with their employer, some based on ethnic or age differences and others due to the length of time they had been employed by their firm. In some cases, they had been employed for at least two years and felt that their employer took reasonable interest in their welfare. In many other instances, particularly with the younger workers, the employment relationship was tenuous.
- When asked whether they would feel comfortable approaching their employer, the Vietnamese employees were much more reluctant to approach their employers about the new program. These employees felt that they may put their position at risk by suggesting that they are asking for more than a job and a wage.

*“If I ask for health insurance [my employer] would rather employ people with Medi-Cal instead of hiring us. So to demand health insurance and cause them problems they will lay us off. If we mention or demand health insurance something might happen to our jobs.”*

*– Vietnamese employee*

- At the same time, several employees expressed that their employer would reap some benefit from providing coverage to his/her employees.

*“It’s good for him as well as us. If we get sick and have no health coverage, maybe it will take two or three days to get to the doctor and we are going to waste that job. My employer will lose his earnings.” – Vietnamese employee*

## **EMPLOYEES’ WILLINGNESS TO MAKE WAGE – BENEFITS TRADEOFF**

- Reactions were mixed on whether employees were willing to take a lower wage in order to receive health insurance coverage. A number of the younger, single employees were less willing to take lower wages for health benefits. Other employees both younger and older, said they would contribute up to \$.50 per hour of their wages for “good” coverage. Yet many employees indicated they could be willing to take up to a \$1 per hour decrease in wages in exchange for receiving comprehensive health benefits.<sup>6</sup>

*“I would be willing depending on the plan they offered me, because I have had emergencies that have cost me a lot. I’d rather have insurance.” – Latino employee*

- Feedback from the employees indicates that their willingness to make the wage-benefits tradeoff, and how much they would choose to lower their wages by, is directly influenced by their assessment of the “comprehensiveness” of benefits that are offered to them. Offering a benefit plan that is comprehensive and provides access to a range of known providers will have a significant effect on the take-up rate of these employees in small firms and their willingness to contribute towards their coverage.

## **EMPLOYER AND EMPLOYEE REACTIONS TO THE WORKING FOR HEALTH PROGRAM**

The hypothetical “Working for Health” program design was generally described to focus group participants as follows:

The purpose of the “Working for Health” program would be to provide subsidized health insurance coverage to low-wage full-time (and possibly permanent part-time) employees of small businesses with between two and fifty employees. Employees earning less than approximately \$12 per hour would be eligible for subsidized coverage.

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<sup>6</sup> Note that the more low-wage employees might have to pay for their health insurance, the more likely a program would suffer adverse selection as largely high-risk employees would opt for coverage. However, because the focus group selection criteria were based on wage level and not family income, it is possible that some of the participants with higher family incomes were the ones who were more willing to forego cash wages in order to obtain health coverage.

"Working for Health" participants would have access to one of several provider systems encompassing local hospitals, community health clinics, and physician offices in Orange County. The benefits covered through the program would include physician office visits, well-child and adult exams, immunizations, hospitalization and prescription drugs, with some minimum copayments. In general, employers would contribute about \$50 towards each employee's premiums. Employees would contribute between 1 to 4 percent of their wages based on their wage level and family size.

Focus group participants were then asked to respond to a series of questions about the proposed program. Their responses are summarized below.

- Knowledge and perception of CalOptima and the CalOptima network. A few participants indicated that in their minds Medi-Cal and CalOptima are synonymous. They apply for Medi-Cal and receive a CalOptima card and therefore do not understand that CalOptima is the local Medicaid managed care plan.

Participants also generally knew more about specific CalOptima providers than about CalOptima the health plan. In general, they had a positive perception of these providers, including CHOC, Fountain Valley and St. Joseph's Hospital. A few participants had heard of CalOptima or had family members who had previously received coverage through the plan. CalOptima was positively identified in these cases as a "good" health plan. This finding is fairly common as patients are more likely to identify their doctor or medical facility rather than the specific health plan that administers the insurance coverage.

- Employer contribution levels. When asked about the proposed contribution levels for employers, a majority of participants thought that they were reasonable and affordable. Most employers indicated that they could contribute approximately \$50 per employee per month for single coverage. Several of the Latino employers indicated they would be willing to pay upwards of \$75 to \$100 per employee per month, whereas the Vietnamese employers were fairly consistent in their response that they could contribute no more that \$50 per employee per month for single coverage. Differences emerged in what they could afford to contribute towards family coverage, with some employers willing to go up to \$100 per family per month and others capping their contribution at \$60 per family per month.
- Employee contribution levels. There was a greater range of responses from employees on what they considered to be "affordable" contributions to their monthly premium. Even though they were earning comparable hourly wages (many earn \$10 per hour or less), employees had vastly different responses to what they were willing to pay towards their monthly premium. There appeared to be more variance depending on how much the participant values or needs coverage, either because they were older employees or had a pre-existing health condition. Employees said they could afford \$20 per month on the low end to \$50 a month on the high end for single coverage, and those interested in family coverage were willing to pay between \$80 and \$150 per month. Again, those employees on the

higher end of the range were most likely in households with higher family incomes, which for privacy reasons, were not revealed during the focus group discussions.

Several employees said they were willing to pay incrementally more for a complete program that includes dental, vision and mental health coverage.

- **Benefits.** Nearly all the employees thought that coverage for hospitalization and pharmacy benefits were essential to the overall benefit package. Dental and vision coverage were also highly desired benefits, with several employees emphasizing their need for dental coverage alone. A few employees who worked in the electronics industry said vision coverage was particularly important given the demands of their work.

In general, employees expressed lukewarm interest in a benefit plan that includes an annual deductible and would prefer paying copayments as they receive services. They were also clear about wanting to contribute to some portion of their coverage as a matter of personal pride and that they would likely receive better service if they are an insured patient.

*“I don’t like to have everything for free. I like to pay and be treated with the respect I deserve.”*  
– Latino employee

- **Provider network.** A critical issue raised by employers and employees alike was whether they would be able to choose from a good provider panel. Employers and employees were unanimous in approving of the providers, particularly the hospitals that would be available (i.e., that are contracted through the CalOptima network). Some were surprised by the various provider options that could be available to them through the "Working for Health" program, as they tended to assume that any coverage they would receive through their employer would be limited. In general participants tended to be more familiar with the names of local hospitals, such as St. Joseph’s Hospital and Children’s Hospital of Orange County (CHOC), rather than specific medical groups.
- **Benefits equity.** When asked whether their contributions should vary based on wage level, family size or another factor, employees most frequently responded that their contributions should be based primarily on wage level and then family coverage status. However, there was some disagreement among employees on the issue of family size and whether it was fair for employees with dependents to be required to pay proportionally more than single employees.

There was general consensus among employers and employees that it would be acceptable for the program to offer a scaled down benefit package to childless workers in order to make it affordable (assuming a subsidy would not be available for these workers) for them to participate. Further research may be required to probe their receptivity to the scaled down benefit design approach relative to offering a comparable benefit design with higher copayments.

The employers were mixed in their responses about wanting choice outside the CalOptima network to include other health plans such as Blue Shield, Kaiser or Blue Cross. Several participants were satisfied with the options available through CalOptima while others indicated a preference for other health plans, particularly if premiums would vary by plan.

- Service. While many participants said that choice of health plan is crucial, others were willing to trade some choice for more comprehensive benefits and good service. Employers and employees discussed previous experiences with some of the larger health plans in which they believed that the service they received was poor. Some mentioned long waiting times to get appointments, lack of access to medications, and negative interactions with their doctors.

*“What’s important is service, not the name and what it covers.” – Latino employer*

- Immigration status. The Latino employer and employee groups voiced extreme caution in building a program that would require participants to provide information on their immigration status. Several of the employers said that it was likely that one or more of their employees did not have full legal status, and that they did not want to scare these employees by enrolling in a program that would ask intrusive questions about their country of origin and their immigration status. These employers were wary about getting involved in any program that may be perceived as jeopardizing their employees’ ability to remain employed with their firm, or where they may be seen as somehow connected to a government program.

*“If the application asks for a social security number and legal status then the employer would feel wary.”*  
*– Latino employer*

Several employers said outright they would not participate in a program if their employees would be asked about their legal status, either for their own or their employees’ interests. In some cases, employers cited prior experiences being fined for employing a worker with nonlegal working status. Two employers expressed concerns about potential litigation if they were asked to probe employees for their immigration or legal status.

*“As an employer I cannot ask about [employees’ legal] status. In fact I wouldn’t even give out an application that asked for their legal status because I can be sued.”*  
*- Latino employer*

- Program length. Employers and employees were skeptical that the "Working for Health" program “sounded too good to be true” and that it would only be around for a short period of time. One employer was concerned about investing the time to get his employees enrolled in the program, only to have it immediately end due to lack of sustainable funding. When asked what a reasonable timeframe is for the

program to be funded, many employers said that a three- to five-year commitment would assure them of the program's viability.

*“What happens many times is that we have been burned too many times. They offer us many things and then they're not true.” – Latino employer*

## **PROGRAM DESIGN CONSIDERATIONS**

Based on the findings from the focus groups with small employers and uninsured low-wage workers, several themes emerged regarding their experience with health insurance coverage and how the Working for Health Program can be structured to reach low-wage employees.

### **A. A Subsidized Health Insurance Program Targeted to Small Employers Will Motivate Some but Not All to Offer Coverage to their Uninsured Employees**

Overall, the employers and employees were anxious for the WFH program to be implemented in Orange County. Several asked to be contacted once the program was underway and many asked for CalOptima's phone number to obtain more information about the program. Another theme consistently stated by both the non-offering small employers and uninsured low-wage workers was that the "Working for Health" program would likely be in high demand due to its relative affordability and expanded choice within a local provider network.

Based on this report's findings, it is likely that a "Working for Health" Program would motivate many non-offering employers to begin offering coverage. There are groups of Latino and Vietnamese employers in Orange County that would like to offer health insurance and would provide this option if subsidies were made available to their employees so that premiums could be affordable for them to take up coverage. Through this group of employers, CalOptima could reach a subset of workers who might not otherwise receive assistance through existing public programs or would remain uninsured.

It is important to note that, although it could form an important part of an overall strategy, a "Working for Health" Program cannot alone provide the solution to covering the County's uninsured. Even with significant subsidies on the table, the program would not stimulate all qualifying non-offering firms to offer coverage. Some small employers will either be unwilling to contribute the minimum amount as compared to not contributing at all (the status quo) or will not want to ask their employees to make the wage-benefits tradeoff for fear of losing those employees who do not value coverage to a competitor offering higher wages and no coverage. There are also specific classes of employees, such as contract, temporary, seasonal, or self-employed workers or employees who will not be reached through this program.

## **B. Coverage for All Employees Is Preferred**

Employers indicated that availability of the program for themselves and their part-time permanent employees is also highly desired. In particular, a number of Latino-owned small firms stated that they would not offer a program that would require them to exclude certain types of employees, whether they earn higher wages or are of questionable legal status. They believed that asking employers to make "bright line" distinctions such as these would put them in a precarious and difficult situation. This would also promote a workplace environment that is inequitable from the employees' perspective.

Employers were not overly concerned about the option of childless workers receiving an affordable yet scaled down benefit package. In their minds the alternatives are less attractive whereby these workers would either pay much higher premiums in the private market or remain uninsured.

Employers and employees also emphasized the importance of designing the "Working for Health" program so that it would not "look and feel" like a government program. The Sharp Health Plan's FOCUS program in San Diego is one model for CalOptima to look to in creating a program that has the feel of private coverage.

## **C. The CalOptima Provider Network Offers Sufficient Choice to Most Employees, Some Employers Would Like Additional Health Plan Choices**

Participating employees identified access to public and private providers as an essential component of the WFH program. A number of employers thought that an advantage of the program was that it would provide employee-choice of local providers, including private hospitals, private physicians and community clinics.

Some of the employers also said that having a broader choice of health plans for themselves and higher wage employees is preferred, particularly if they may be required to contribute more to their monthly premiums. The option of selecting from several plans may encourage participation and provide an added value relative to their options in the individual market, even though the expected contributions to their monthly premiums would be higher as compared to the lower-wage employees.

## **D. Employees and Employers Want Comprehensive Coverage that Includes Dental and Vision Coverage, But Are Concerned about High Deductibles**

Employees and Employers emphasized the need for health coverage to be comprehensive. A subgroup of employees indicated they would likely be willing to pay more on a monthly basis for coverage that includes dental and vision coverage. Several employees were concerned, however, about the attachment of high deductibles to the program. They indicated a higher comfort level with reasonable copayments paid on a per use basis rather than having to keep track of an annual deductible. There was some early indication that, if the program can demonstrate value over time, both employers and employees would

increase their contributions so they would continue to have access to comprehensive benefits and choice of providers.

#### **E. Employee Contribution Levels Should Be Set Relative to Contribution Levels Under Similar Small Group Benefit Plans**

The issue of pricing was raised throughout the focus groups primarily in terms of what participants would be willing to pay for coverage through the WFH program. However, CalOptima and its partners will need to explore competitive pricing amongst other benefit plans that are available to the small group market. In addition, it will be important for the program's viability that the WFH contribution levels be comparable to what would be available to eligible parents under a potential Healthy Families parental expansion, with the goal of ensuring that the program achieves adequate enrollment.<sup>7</sup>

#### **F. Keeping the Program Simple and Easy to Administer will Attract and Keep Employers and Employees Enrolled in the Program**

Small employers have minimal staff and time to oversee and administer a complex benefit plan for their employees. However, a majority of these Latino and Vietnamese small business owners indicated that they retain a bookkeeper or accountant and utilize payroll firms to manage employee deductions. Some employers expressed concern about the amount of time filling out paperwork, but for the most part they were comfortable explaining the program to their workers and answering questions as they arise. After hearing about the program, employers thought it was attractive enough to warrant extra time on the administration end. They did caution, however, that too much paperwork and inefficient program management would lead them to reconsider their participation.

The employees were not too concerned that, in order to enroll in the program and receive a subsidy, their employer would have to confirm their wage level with the program. As discussed earlier, the Latino employers and employees expressed the most concern about sharing information on applicants' immigration status.

#### **G. Multiple Communication Channels Are Key to Promoting the Working for Health Program**

The employers and employees in both ethnic groups generally cited similar communication strategies for promoting the WFH program. The most often cited venues included employer presentations, ethnic media, "word-of-mouth" campaigns, community-based organizations and community leaders.

The Latino and Vietnamese employee groups agreed that it would be more effective for the employer to be introduced to the program directly, rather than first hearing about it through

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<sup>7</sup> Governor Gray Davis vetoed General Fund expenditures in the 2002-03 California Budget that would have initiated expansion of the Healthy Families Program to provide coverage to parents with incomes up to 200 percent of FPL. Due to projected budget deficits through FY 2004, the Governor's office has not confirmed how long the parental expansion will be delayed.

their workers. Both employers and employees suggested that presentations or informational meetings would be the best way to inform employers of the program and answer their questions or concerns. In addition to going out to firms directly, participants thought that other possible locations for employer presentations included local job fairs, community events, small business association meetings, the Vietnamese Commerce Association, and the Latin Business Council. Similarly, all participant groups mentioned that presentations to workers would be a valuable way to market the WFH program and that, once these presentations were made, “word of mouth” would spread quickly about the program.

The use of ethnic media outlets was consistently mentioned as one of the best methods to communicate the program. Employees identified specific ethnic radio programs and newspaper advertisements as the leading venues to reach the target population. Others cited strategies included the use of flyers, particularly in doctor’s offices and clinics, and advertising on billboards and bus stops. A couple of employers mentioned using Healthy Families’ marketing strategies, such as “going out to the street” and using a multilingual information hotline. More specifically, Latino employees indicated several possibilities for a program spokesperson to reach their community, including “the Cucui” on radio station 101.9, Edward James Olmos, Don Francisco, and Loretta Sanchez.

Finally, several references were made to local community and faith-based organizations to reach uninsured workers. Churches were most frequently mentioned by the Latino employees and shopping areas by the Vietnamese employees. Employers and employees in both communities agreed that no single avenue is preferred and instead the program should use a combination of promotional strategies to raise awareness and encourage small business participation.

## **APPENDIX A**

### Description of the Working for Health Program

The purpose of the “Working for Health” program is to provide subsidized health insurance to lower-wage full-time (and potentially permanent part-time) employees of small businesses with 2 to 50 employees.

Under this new program, full-time or permanent part-time employees earning less than \$12.00 per hour would be eligible to receive subsidized coverage.<sup>8</sup> For employees to be eligible for this program, small employers would select to join the Working for Health program so their employees could sign up for coverage through the CalOptima provider network. This network includes Children's Hospital of Orange County, University of California-Irvine Medical Center, Universal Care, Family Choice Medical Group/ Fountain Valley Hospital, United Care Medical Group/St. Joseph's Hospital, and ARTA Medical Group/United Western Medical Center.)

The services covered through this program would include physician office visits, well child and adult exams, immunizations, hospitalization and urgent care, and prescription drugs. Copayments would range from \$5 to \$10 for preventive and primary care services and \$50 for emergency room services.

The cost of the health insurance provided through the Working for Health program would be partially paid by government or private charitable funds. This subsidy would be available through the Working for Health program, and help to reduce the cost of coverage for participants. Employers would be asked to contribute approximately \$50 per month per employee, with some adjustments based on the employee's wage level and family size. Employee contributions would range between 1 to 4 percent of their wages depending on their wage level and family size.

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<sup>8</sup> Although employee eligibility for a subsidy will be based on family income, to simplify the discussion we presented subsidy-eligibility in terms of wage.