IDENTIFYING VULNERABLE ASIAN AMERICANS, NATIVE HAWAIIANS, AND PACIFIC ISLANDERS IN CALIFORNIA UNDER HEALTH CARE REFORM

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APIAHF
ASIAN & PACIFIC ISLANDER AMERICAN HEALTH FORUM

The Asian & Pacific Islander American Health Forum (APIAHF) is a health justice non-profit organization dedicated to improving the health and well-being of more than 17 million Asian Americans, Native Hawaiians, and Pacific Islanders living in the United States and its jurisdictions. We believe that all persons have the right to be healthy, the right to live in a thriving community, and the right to quality, affordable, and accessible health care.

For the past 26 years, APIAHF has worked with community advocates, public health leaders, and policymakers to generate policies, programs, and systems changes to improve the health of Asian American, Native Hawaiian, and Pacific Islander communities. Through our policy and advocacy efforts, APIAHF was instrumental in the creation of the White House Initiative on Asian Americans and Pacific Islanders, fought for the passage of the Patient Protection and Affordable Care Act, and continues to demand the inclusion of Asian Americans, Native Hawaiians, and Pacific Islanders in the collection and reporting of local, state, and national health data. APIAHF works with local and state-based CBO's in 20 states and territories who provide services and advocate for AA and/or NHPI communities.

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APIAHF envisions a world where all people share responsibility and take action to ensure healthy and vibrant communities for current and future generations.

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Our work derives from three core values:

Respect because we affirm the identity, rights, and dignity of all people.

Fairness in how people are treated by others and by institutions, including who participates in decision making processes.

Equity in power, opportunities, and resources to address obstacles hindering vulnerable communities and groups from living the healthiest lives.

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INTRODUCTION

Signed into law in March of 2010, the Patient Protection and Affordable Care Act (ACA) sought to reform the nation's health care system and provide expanded health insurance coverage for Americans. Several provisions of the ACA that will take effect in 2014 may be particularly helpful in extending health care coverage for disadvantaged Asian American (AA) and Native Hawaiian and Pacific Islander (NHPI) individuals and families who are currently uninsured, particularly those with lower incomes. They include 1) the expansion of Medicaid to cover eligible individuals and families with incomes, including childless adults, at or below 138 percent of the Federal Poverty Level (FPL); 2) subsidies to purchase health insurance in the Health Insurance Marketplace, developed and managed by the state and/or federal government, for which individuals and families with incomes between 138 and 400 percent of the FPL will be eligible; and 3) allowing small businesses with up to 50 employees to buy health coverage through a Small Business Health Options Program (SHOP) Marketplace, which will offer better health insurance coverage options at an affordable price than is currently available.[1]

Despite ACA's promise to make health care available for most of the U.S. population, there are barriers that currently uninsured AAs and NHPIs may face in accessing health care. First, many AAs and NHPIs are foreign-born and run or work for small businesses. Small businesses are less likely than large employers to provide health insurance (Huang and Carrasquillo, 2008). The lack of employer-provided insurance is the single most important reason why immigrants lack health insurance coverage; foreign-born adults are nearly three times as likely to be uninsured as native-born (Buchmueller et al., 2007).

Many AA adults — about 59%, according to the 2009-2011 American Community Survey, compared to about 16% of NHPIs and 12% Whites — are foreign-born and run or work for small businesses. Because small businesses with fewer than 50 employees are not mandated to provide coverage to their employees under the ACA, there is a distinct possibility that currently uninsured AAs and NHPIs who work for small businesses will continue to be uninsured. Second, many uninsured persons, both adults and children, who are eligible to access public insurance may not access it due to various administrative and psychological barriers. Such barriers are documented in the literature, mostly concerning Latino health, and include limited information on (or confusion over) eligibility requirements, administrative hassle obstacles associated with submitting an application, stigma associated with public programs, and misinformation that accessing public benefits may have negative repercussions for immigrants (Hearst et al., 2010). While there is little literature on the barriers lower-income AAs and NHPIs face in accessing public insurance, they may face similar obstacles.

1 With regard to immigration status, "Lawfully Present Immigrants" are eligible to enroll in the health insurance marketplaces and get subsidized insurance. However, current Federal law restricts their access to Medicaid coverage during their first 5 years in the U.S. and this restriction will remain in effect even after 2014. California is different from most states in that many legal immigrants are still eligible for state-funded Medi-Cal (Medicaid in California) under the state's PRUCOL ("Permanently Residing in the U.S. under Color of Law") definition. PRUCOL is a Medi-Cal classification which includes immigrants who are in the process of applying for a change in immigration status and pending review. In California, these individuals can get Medi-Cal coverage with no waiting period if they meet the income eligibility criteria. Currently, there are 14 states that provide state-only Medicaid benefits for all legal immigrants during their first 5 years in the U.S.

While many AAs and NHPIs who run or work for small businesses may thus continue to be uninsured, little is known about who they are and what specific barriers they may experience in accessing health care. In addition, there is little information on the extent to which AA and NHPI small business owners and employees are informed about the ACA implementation currently underway. To fill these important information gaps, Asian & Pacific Islander American Health Forum (APIAHF) conducted a two-component research project from 2012 to 2013, utilizing both quantitative and qualitative research methods. This report presents key findings of this project. The focus of the project and this report are on AAs and NHPIs in California, where about one in three AAs and one in four NHPIs in the U.S. live, according to the 2010 U.S. Census.

The quantitative research component is intended to improve understanding of demographic and socioeconomic profiles of AA and NHPI small business owners and employees that may serve as social determinants of health for these populations, as well as their health conditions, health status, and health care access and use. To achieve this objective, we conducted a secondary analysis of 2005 to 2009 California Health Interview Survey (CHIS) data. The main goal of this effort is to identify the predictors of uninsurance for these populations and to understand the impact of uninsurance on their health and health care use.

The qualitative research component consists of a series of focus groups conducted with members of AA and NHPI ethnic groups with high uninsurance rates, as well as in-depth interviews with key informants who serve such communities. Our objective here was to gain a deeper understanding of high uninsurance rates in AA and NHPI communities in the context of their real life experiences; how AAs and NHPIs in immigrant communities access health insurance and health care and the barriers they experience in doing so; what specific barriers are posed for small business owners and employees; how small business owners and employees perceive the provisions of the ACA intended to expand coverage; and to what extent the way in which the ACA is implemented in California is likely to be effective in increasing coverage in immigrant communities.

NOTE: Medicaid in California is called Medi-Cal, so all references to Medicaid expansion in this report refer to Medi-Cal.

QUANTITATIVE RESEARCH FINDINGS: ANALYSIS OF CALIFORNIA HEALTH INTERVIEW SURVEY

PROFILES OF ASIAN AMERICAN, NATIVE HAWAIIAN, AND PACIFIC ISLANDER SMALL BUSINESS OWNERS AND EMPLOYEES IN CALIFORNIA

Demographic and Socioeconomic Characteristics, Health Care Access & Health Status

According to the California Health Interview Survey (CHIS), there were an estimated 877,000 Asian American (AA) and 19,000 Native Hawaiian and Pacific Islander (NHPI) adults who owned or worked for small businesses with up to 50 employees in California in 2009. They accounted for 12% and 0.3%, respectively, of California's workforce working in small businesses with up to 50 employees. AAs accounted for about 12% and NHPIs about 0.3% of California's population in the same year. While having a small business category with less than 50 employers (instead of up to 50) would be more meaningful in the context of the ACA requirements the cut-off point available in CHIS was up to 50 employees (which was used to construct a measure for our "small business" category in this report). Also, there is no information in CHIS on whether the adult was a small business owner or employee; therefore our small business category for our CHIS analysis included both.

We first conducted a series of bivariate analyses to understand socioeconomic characteristics of AA and NHPI small business owners and employees in California, essentially to determine whether AA and NHPI small business owners and employees are at a greater disadvantage than those who work for large employers. We examined the associations of employer type (i.e., employment in small businesses versus for larger employers) with social determinants of health, such as income, education, immigration/citizenship status, and English language proficiency, and health care access (Kao, 2010; Kim et al., 2011; Lee, 2011; Lee and Choi, 2009).

As Table 1 shows, AA small business owners and employees were indeed likely to have lower socioeconomic status (SES) than those who worked for large employers (51 or more). For example, the proportion of AA adults who had a four-year college or more advanced degree was lower for small business owners and employees (30%) than for employees working for large employers (42%). Similarly, a lower proportion of small business owners and employees (50%) had incomes higher than 300% of the Federal Poverty Level (FPL) than those who worked for large employers (67%).

Table 1. Demographic & Socioeconomic Profiles of AA Small Business Owners & Employees

	Adults who owned or worked for small businesses (up to 50 employees)	Adults who worked for large employers (51+ employees)	p-value
Gender: Male	56%	54%	***
Female	44%	46%	
Age: < 26	19%	18%	****
27 - 39	28%	31%	
40 - 54	34%	36%	
55 - 64	14%	12%	
65+	5%	3%	
Educational level: Less than 4-year college degree	70%	58%	****
4-year college degree or higher	30%	42%	
Income Level: < 100% of FPL	16%	7%	****
100-199% of FPL	19%	13%	
200-299% of FPL	14%	13%	
300% of FPL	51%	67%	
Nativity: Foreign-born	38%	29%	****
U.S.-born	61%	71%	
Citizenship & Immigration Status: US-born	61%	71%	****
Naturalized	16%	17%	
Non-citizen (with green card)	12%	8%	
Non-citizen (without green card)	11%	4%	
Years of residence in US: < 5 years	10%	7%	****
5 - 9 years	15%	11%	
10 - 14 years	15%	13%	
15+ years	60%	69%	
Limited English Proficiency (LEP)	42%	23%	****
Ethnicity: Chinese	40%	60%	****
Japanese	39%	61%	
Korean	52%	48%	
Filipino	30%	70%	
South Asian	27%	73%	
Vietnamese	47%	53%	
Southeast Asian	46%	54%	
Mixed Asian American	39%	61%	

Note: FPL stands for Federal Poverty Level; * $p < 0.05$, ** $p < 0.01$, *** $p < 0.001$, **** $p < 0.0001$

Vietnamese were analyzed separately from other Southeast Asian groups – Cambodians, Hmong, and Laotians – because Vietnamese were over-sampled and could therefore provide reliable estimates. Other Southeast Asian groups had comparatively smaller sample sizes and were aggregated in the analyses as a result.

Nativity and citizenship status were also significantly associated with employer status, with the proportion of U.S.-born citizens being lower for small business owners and employers (61%) than for those who worked for large employers (71%). Conversely, a higher proportion of AA small business owners and employees were non-citizens with (12%) or without green cards (11%) than those who worked for large employers (8% and 4%, respectively). For the most part, the proportion of the U.S.-born appears to be much higher for AA working adults in California than the national average for AA adults of about 40%. Among foreign-born AA working adults, a somewhat higher proportion of small business owners and employees (10%) were newer immigrants who had lived in the U.S. for fewer than 5 years, compared to those who worked for large employers (7%). Also among the foreign-born, a substantially higher proportion (42%) of AAs who owned or worked for small businesses had limited English proficiency than those who worked for large employers (23%).

The proportion of small business owners or employees was the highest for Koreans (52%), followed by the Vietnamese (47%) and other Southeast Asians (46%). What is also worth noting is the relatively high proportion (37%) of small business owners or employees for AA working adults. Even in the ethnic groups with the lowest proportions of small business owners or employees, over one in four working adults—about 27% for South Asians and 30% for Filipinos—were small business owners or employees.

Consistent with past research findings that small businesses are less likely to provide health insurance coverage (Buchmueller et al., 2007; Huang and Carrasquillo, 2008), AA small business owners or employees had lower rates of health insurance coverage than those who worked for large employers. As Table 2 shows, the uninsurance rate was significantly higher for AAs who owned or worked for small businesses (27%) than those who worked for large employers (10%). Much of this disparity comes from the considerably lower rate of private insurance coverage for small business owners and employees (56%) than those who worked for large employers (81%). The rate of public insurance coverage provided for individuals and families with lower incomes, the elderly, the disabled, and others who need public assistance was higher for AA small business owners or employees (16%) compared to those who worked for large employers (9%).

Table 2. Health Care Access & Health Status of AA Small Business Owners & Employees

	Adults who owned or worked for small businesses (up to 50 employees)	Adults who worked for large employers (51+ employees)	p-value
Insurance coverage: Uninsured	27%	10%	****
Public insurance	16%	9%	
Private insurance	56%	81%	
Had usual place to go to when sick or needing health advice	76%	86%	****
Had visited doctor during the past 12 months	74%	83%	****
Had visited an ER for own health in the past 12 months	16%	17%	**
Had Poor/fair health	16%	12%	****
Had Asthma	11%	14%	****
Had Diabetes/borderline	6%	6%	p>0.05
Had Heart Disease	4%	3%	**
Had Hypertension	19%	20%	*
Had Chronic condition	32%	34%	***
Disabled due to physical, mental, emotional condition	22%	19%	****

Note: *p < 0.05, ** p < 0.01, *** p < 0.001, **** p < 0.0001

Inevitably, the disparities in health insurance coverage, particularly private insurance, spill over into health care access and use. That is to say, AA adults who owned or worked for small businesses (76%) were less likely to have a regular provider than those who worked for large employers (86%); the former (74%) were also less likely than the latter (83%) to have visited doctors' offices in the past twelve months. This is consistent with past research which has found the lack of health insurance to be the most consistent predictor of unmet heath care needs including medical checkups, screening, and other ambulatory care (Buchmueller et al., 2005; Culica et al., 2002; DeVoe et al., 2008). The two groups differed little in emergency room use in the past year (16% versus 17%) (Table 2).

Employer type was not highly correlated with the chronic health conditions included in our analysis (Table 2). The prevalence of asthma and hypertension was slightly higher for those who worked for large employers (14% and 20%, respectively) than for small business owners or employees (11% and 19%, respectively). The opposite was the case for heart disease. The difference in diabetes (including pre-diabetes) between the two groups was not statistically significant. However, small business owners and employees (16%) were more likely to report poor or fair health, as opposed to excellent, very good, or good health, compared to those who worked for large employers (12%). Additionally, the former were more likely to have disability due to physical, mental, and emotional conditions than the latter (22% versus 19%).

In summary, AA small business owners and employees were at a greater disadvantage than those who worked for large employers. The former were more likely than the latter to have lower incomes and educational levels, and to have limited English proficiency (LEP), all of which are likely to be associated with poorer health and greater disparities in accessing health care as suggested by the current literature (Kim et al., 2011; Lee and Choi, 2009; Ponce et al., 2006), and reconfirmed in our analysis.

The associations between socio-demographics and employer type observed in AAs, which suggested lower socioeconomic status of small business owners or employees compared to those who worked for large employers, were not apparent in NHPIs (Table 3), and most of our results involving NHPIs were not statistically significant (Table 3). This may be in part because of the small number of NHPIs included in our sample (N=165) and the associated low statistical power which may have limited the ability to detect significant associations. The different profiles of AA and NHPI small business owners and employees may also be due to the ambiguity of small business category we used that included both owners and employees and to the lack of further information in CHIS about this, as we stated previously. To the extent that employers and employees are differentially represented among AAs and NHPIs who work in the small business sector, their socioeconomic profiles may appear different. We note this as a limitation of this study.

Table 3. Demographic & Socioeconomic Profiles of NHPI Small Business Owners & Employees

	Adults who owned or worked for small businesses (up to 50 employees)	Adults who worked for large employers (51+ employees)	p-value
Gender: Male	53%	41%	p>0.05
Female	47%	59%	
Age: < 26	35%	11%	**
27 – 39	36%	30%	
40 – 54	20%	44%	
55 – 64	10%	13%	
65+	0%	1%	
Educational level: Less than 4-year college degree	70%	76%	p>0.05
4-year college degree or higher	30%	24%	
Income Level: < 100% of FPL	10%	9%	p>0.05
100-199% of FPL	19%	9%	
200-299% of FPL	22%	12%	
300% of FPL	48%	70%	
Nativity: Foreign-born	18%	31%	p>0.05
U.S.-born	82%	69%	
Citizenship and Immigration Status: US-born	82%	69%	p>0.05
Naturalized	6%	17%	
Non-citizen (with green card)	12%	14%	
Non-citizen (without green card)	0%	0%	
Years of residence in US: < 5 years	0%	14%	p>0.05
5 - 9 years	0%	10%	
10 - 14 years	36%	35%	
15+ years	64%	42%	
Ethnicity: Native Hawaiian	44%	56%	p>0.05
Samoan	40%	60%	
Guamanian	26%	74%	
Tongan	42%	58%	
Fijian	20%	80%	
Polynesian	31%	69%	
Other Pacific Islanders	49%	51%	
Limited English Proficiency (LEP)	0%	6%	p>0.05

Note: FPL stands for Federal Poverty Level; * $p < 0.05$, ** $p < 0.01$, *** $p < 0.001$, **** $p < 0.0001$

Health conditions and health status were not significantly associated with employer type for NHPIs (Table 4). However, health insurance coverage and health care access were significantly associated with employer type in the way we implicitly hypothesized. That is to say, NHPI small business owners and employees were more likely be uninsured (25%) than their counterparts who worked for large employers (6%). Nonetheless, the disparities in private insurance coverage for the two NHPI groups (67% of small business owners and employees compared to 79% for those who worked for large employers) were not as pronounced as for AA groups. A larger contrast between the two NHPI subgroups lie in the proportions of persons who had regular providers, with only about 60% of small business owners or employees likely having regular providers, compared to about 88% of those who worked for large employers. Health care use (i.e., office-based doctor visit and ER visit) was not significantly associated with employer type.

Table 4. Health Care Access & Health Status of NHPI Small Business Owners & Employees

	Adults who owned or worked for small businesses (up to 50 employees)	**Adults who worked for large employers (51+ employees)**	p-value
Insurance coverage: Uninsured	25%	6%	*
Public insurance	7%	15%	
Private insurance	67%	79%	
Had usual place to go to when sick or needing health advice	60%	88%	**
Had visited doctor during the past 12 months	83%	86%	p>0.05
Had visited an ER for own health in the past 12 months	15%	24%	p>0.05
Had Poor/fair health	19%	16%	p>0.05
Had Asthma	11%	24%	p>0.05
Had Diabetes/borderline	14%	11%	p>0.05
Had Heart Disease	4%	8%	p>0.05
Had Hypertension	18%	30%	p>0.05
Had Chronic condition	40%	49%	p>0.05
Disabled due to physical, mental, emotional condition	28%	22%	p>0.05

Note: *p < 0.05, ** p < 0.01, *** p < 0.001, **** p < 0.0001

Eligibility for Medi-Cal and Subsidized Insurance

Noting that the provisions of the ACA to expand health care coverage, specifically concerning income levels, may differentially affect diverse segments of AA small business owners and employees, we sought to understand socioeconomic profiles, as well as health care coverage and access, of those subgroups. Due to the small number of NHPIs, we were unable to conduct similar analyses for NHPI subgroups compared to the analysis for AA subgroups.

Presented in Table 5 are the demographic and socioeconomic profiles of two AA subgroups in California: 1) AA small business owners or employees with the profile that would make them eligible for Medi-Cal, starting January 2014 (i.e., U.S. citizens or legal residents with incomes up to 138% of the FPL, who we refer to as the "Medi-Cal group"); and 2) AA small business owners and employees who would be eligible for subsidized insurance, also starting in January 2014 (i.e. legal residents with incomes between 138% and 400% of the FPL, referred to here as the "subsidized insurance group"). As a reference group, the profiles of AA small business owners and employers with incomes higher than 400% of the FPL (referred to as the "higher-income group") are also included in this table. Unless noted otherwise, all the findings reported below are statistically significant at the level of $p<.05$.

Table 5. Demographic & Socioeconomic Profiles of AA Small Business Owners or Employees Eligible for Medi-Cal and for Subsidized Insurance

	Eligible For Medi-Cal	Eligible For Subsidized Insurance	Higher Income	p-value
Gender: Male	18%	35%	48%	***
Female	20%	37%	43%	
Age: < 26	28%	39%	33%	****
27 – 39	19%	38%	43%	
40 – 54	18%	34%	47%	
55 – 64	11%	31%	59%	
65+	10%	34%	55%	
4-year college degree or higher: No	25%	42%	33%	****
Yes	6%	24%	70%	
Ethnicity: Chinese	22%	33%	45%	****
Japanese	7%	32%	61%	
Korean	17%	39%	44%	
Filipino	18%	44%	38%	
South Asian	7%	33%	60%	
Vietnamese	33%	45%	22%	
Southeast Asian	20%	42%	38%	
Mixed Asian American	23%	34%	43%	
Nativity: Foreign-born	13%	34%	52%	****
U.S.-born	30%	39%	31%	
Citizenship and Immigration Status: US-born	13%	34%	52%	****
Naturalized	23%	40%	37%	
Non-citizen (with green card)	42%	40%	18%	
Years of residence in US: < 5 years	42%	24%	34%	***
5 - 9 years	38%	30%	33%	
10 - 14 years	27%	38%	34%	
15+ years	29%	42%	30%	
Limited English Proficiency (LEP): No	22%	41%	37%	****
Yes	51%	39%	10%	

Note: *p < 0.05, ** p < 0.01, *** p < 0.001, **** p < 0.0001

Vietnamese were analyzed separately from other Southeast Asian groups – Cambodians, Hmong, and Laotians – because Vietnamese were over-sampled and could therefore provide reliable estimates. Other Southeast Asian groups had comparatively smaller sample sizes and were aggregated in the analyses as a result.

The proportion of those who would be eligible for Medi-Cal was higher for younger populations, particularly among those ages 26 or younger, than for older. The disparities related to education is striking, with only about 6% of AA business owners and employees who had four-year college or advanced degrees having incomes low enough to be eligible for Medi-Cal, compared to about 25% of those who did not have college degrees. The proportion of those who were eligible for subsidized insurance was also lower for those with college degrees (24%) than for those without college or advanced degrees (42%). Therefore, it appears that more AA adults without college degrees were likely to benefit from Medi-Cal expansion and subsidized insurance to be provided under the ACA.

Among the different AA subgroups, the proportion of those eligible for Medi-Cal was the highest for the Vietnamese (33%), followed by AAs of mixed races (23%), the Chinese (22%), and Southeast Asians (20%), and the lowest for the Japanese (7%) and South Asians (7%). The proportion of those eligible for subsidized insurance was also the highest for the Vietnamese (45%), followed by Filipinos (44%), Southeast Asians (42%), and Koreans (39%). Ethnic differences aside, the high proportions of AA small business owners and employees who would be eligible for Medi-Cal (and particularly subsidized insurance) are striking, as they range from over 30% to close to 50% of AAs in each of the ethnic groups. With the exception of Japanese and South Asians, significant proportions of most AA ethnic groups would be eligible for Medi-Cal coverage and subsidized insurance under the ACA. On average, about one in five of AA small business owners and employees would be eligible for Medi-Cal and almost two in five AA small business owners and employees would be eligible for subsidized insurance.

The proportion of AA small business owners and employees who would be eligible for Medi-Cal was over twice as high for the foreign-born (30%) as for their U.S.-born counterparts (13%). The proportions of U.S.-born and naturalized citizens were much higher for the subsidized insurance group than for the Medi-Cal group: while only about 13% and 23% of small business owners and employees who were U.S.-born citizens or naturalized citizens would be eligible for Medi-Cal, respectively, about 34% and 40% of those who would be eligible for subsidized insurance were U.S.-born and naturalized citizens. It appears that LEP may be a greater concern for the Medi-Cal group than for the subsidized group: in the Medi-Cal group, a majority (51%) of persons likely to have LEP, compared to 22% of those without LEP, whereas a slightly higher proportion of those without LEP (41%) than those with LEP (39%) would be eligible for subsidized insurance.

Health Insurance Coverage by Eligibility for Medi-Cal or Subsidized Insurance

To help inform targeted efforts to expand coverage for the two subgroups, we examined what specific demographic and socioeconomic characteristics were associated with insurance status for these two subgroups (Table 6).

Table 6. Health Insurance Coverage for AA Small Business Owners & Employees Eligible for Medi-Cal & Subsidized Insurance

	Eligible for Medi-Cal				Eligible for Subsidized Insurance			
	Un-insured	**Public Insurance**	**Private Insurance**	p-value	**Un-insured**	**Public Insurance**	**Private Insurance**	p-value
Gender: Male	48%	28%	25%	****	35%	13%	52%	****
Female	37%	39%	24%		22%	17%	61%	
Age: < 26	39%	33%	28%	****	34%	14%	51%	****
27 - 39	41%	36%	23%		29%	10%	61%	
40 - 54	49%	28%	24%		32%	7%	61%	
55 - 64	48%	25%	27%		24%	10%	66%	
65+	4%	92%	3%		1%	95%	4%	
4-year college degree or higher: No	43%	34%	22%	****	31%	16%	53%	****
Yes	35%	22%	43%		20%	12%	68%	
Ethnicity: Chinese	30%	25%	45%	**	23%	8%	69%	***
Japanese	39%	28%	33%		10%	10%	80%	
Korean	68%	24%	8%		51%	11%	37%	
Filipino	32%	29%	39%		22%	23%	55%	
South Asian	42%	6%	52%		27%	6%	68%	
Vietnamese	23%	51%	25%		28%	5%	68%	
Southeast Asian	52%	40%	8%		35%	22%	43%	
Mixed Asian American	39%	30%	31%		12%	10%	78%	
Nativity: Foreign-born	40%	36%	24%	p> 0.05	26%	15%	58%	***
U.S.-born	45%	30%	25%		34%	14%	52%	
Citizenship and Immigration Status: US-born	40%	36%	24%	-	26%	15%	58%	-
Naturalized	35%	31%	33%		26%	15%	59%	
Non-citizen (with green card)	51%	29%	19%		44%	12%	44%	
Non-citizen (without green card)	0%	0%	0%		0%	0%	0%	
Years of residence in US: < 5 years	63%	26%	12%	p> 0.05	63%	26%	12%	p> 0.05
5 - 9 years	39%	35%	26%		39%	35%	26%	
10 - 14 years	40%	32%	28%		40%	32%	28%	
15+ years	44%	30%	26%		44%	30%	26%	
Limited English Proficiency (LEP): No	41%	35%	24%	p> 0.05	32%	15%	53%	*
Yes	48%	31%	21%		40%	14%	46%	

Note: * $p < 0.05$, ** $p < 0.01$, *** $p < 0.001$, **** $p < 0.0001$

In both groups, a higher proportion of males (46% in the Medi-Cal group and 35% in the subsidized insurance group) was uninsured than females (37% in the Medi-Cal group and 22% in the subsidized insurance group). While the uninsurance rate was the highest for those ages 40-64 in the Medi-Cal group, the youngest under the age of 27 were most likely to be uninsured in the subsidized insurance group. In both groups, the uninsurance rate was higher for those who did not have four-year college degrees (43% in the Medi-Cal group and 31% in the subsidized insurance group) than those who did (35% in the Medi-Cal group and 20% in the subsidized insurance group). The public insurance coverage rate was higher for those who did not have four-year college degrees than those who did in both groups. Conversely, the private insurance coverage rate was higher for those who had four-year college degrees than those who did not in both groups, with the disparities being greater in the Medi-Cal group, with those who graduated from four-year colleges (43%) being almost twice as likely to private insurance as those who did not (22%).

Insurance coverage rates varied by ethnicity in both groups (Table 6). Koreans had the highest uninsurance rate (68% in the Medi-Cal group and 51% in the subsidized insurance group), followed by Southeast Asians (52% in the Medi-Cal group and 35% in the subsidized insurance group). Beyond these two ethnic groups, South Asians (42%), Japanese (39%), and AAs of mixed ethnicity (39%) had higher uninsurance rates than the rest in the Medi-Cal group, and Vietnamese (28%) and South Asians (27%) had higher rates than the rest in the subsidized insurance group. The high uninsurance rates for Southeast Asians and Koreans in the Medi-Cal group are explained largely by the low private insurance rates for them (about 8% for both), whereas for South Asians in this group it is due in large part to the low public insurance rate (6%), as they had a high private insurance rate (52%), the highest among all AA ethnic groups. In the subsidized insurance group, Filipinos (23%) and Southeast Asians (22%) had high public insurance rates, and the Japanese (80%) had high private insurance rates, followed by AAs of mixed races (78%), the Vietnamese (68%), and South Asians (68%). Koreans had the lowest private insurance coverage rate (37%), and Vietnamese (5%) and South Asians (6%) had the lowest public insurance coverage rates in the subsidized insurance group. Since the reasons for being uninsured are diverse across ethnic groups, diverse strategies tailored to the specific socioeconomic profiles and insurance status of each ethnic group might be needed to help increase their insurance coverage.

Uninsurance rate was higher for the U.S.-born than their foreign-born counterparts in the subsidized insurance group, whereas nativity was not significantly associated with uninsurance for the Medi-Cal group. U.S.-born and naturalized citizens had a lower uninsurance rate (both at 26%) than permanent residents (44%) in the subsidized insurance group, whereas naturalized citizens, interestingly, had a lower rate of uninsurance than U.S.-born citizens in the Medi-Cal group. The length of residence in the U.S. was not significantly associated with insurance status in either group. A higher proportion of adults with LEP (48%) was uninsured than those without LEP (41%) in the Medi-Cal group. Similarly, a higher proportion of adults with LEP (40%) was uninsured than those without LEP (32%) in the subsidized insurance group.

Health Conditions & Health Care Use by Insurance Status

We also examined whether insured AA small business owners and employees in the two subgroups were likely to have better health status than their uninsured counterparts. As Table 7 shows, in both subgroups, those without insurance were more likely than the insured to report their health being fair or poor health, as opposed to excellent, very good, or good. The differences associated with insurance status were greater for those eligible for Medi-Cal (35% vs. 25%) than those eligible for subsidized insurance (18% vs. 14%). It is also worth noting that the uninsured with incomes low enough to be eligible for Medi-Cal were more likely to be vulnerable to ill health than those with higher incomes due to various risk factors associated with low incomes, which may be exacerbated by the lack of access to health care (Chittleborough et al., 2009; Medicine, 1996; Yen and Syme, 1999).

Table 7. Health Care Use & Health Status by Health Insurance Status: AA Small Business Owners Eligible for Medi-Cal & Subsidized Insurance

	Eligible For Medi-Cal			Eligible For Subsidized Insurance		
	Insured	**Uninsured**	p-value	**Insured**	**Uninsured**	p-value
Had usual place to go to when sick or needing health advice	76%	46%	****	86%	55%	****
Had visited doctor during the past 12 months	75%	55%	****	83%	55%	****
Had visited an ER for own health in the past 12 months	20%	13%	***	18%	11%	****
Had Poor/fair health	25%	35%	**	14%	18%	**
Had Asthma	11%	10%	p>0.05	13%	11%	p>0.05
Had Diabetes/borderline	9%	10%	p>0.05	8%	6%	p>0.05
Had Heart Disease	3%	4%	p>0.05	4%	3%	p>0.05
Had Hypertension	17%	17%	p>0.05	22%	18%	*
Had Chronic condition	32%	31%	p>0.05	36%	31%	*
Disabled due to physical, mental, emotional condition	28%	26%	p>0.05	23%	25%	p>0.05
Received Flu Shot, Past Year	22%	16%	**	23%	11%	****
Compliance with Colonoscopy/Sig/Fobt Screen Test: In Compliance	46%	26%	****	56%	20%	****
Not in Compliance	13%	12%		14%	11%	
Never	42%	62%		30%	69%	
Mammogram: Within past 2 years	81%	58%	****	82%	56%	****
Over 2 years ago	11%	29%		14%	30%	
Never	7%	12%		4%	15%	
PAP Screen : Within past 2 years	77%	65%	*	79%	69%	****
3 or more years	6%	11%		6%	13%	
Never	14%	20%		9%	14%	
Had hysterectomy	3%	4%		6%	3%	

Note: *p < 0.05, ** p < 0.01, *** p < 0.001, **** p < 0.0001

While none of the four common chronic conditions considered — asthma, diabetes, hypertension, and heart disease — were significantly associated with insurance status for either group (p>.05), a somewhat higher proportion of the insured (36%) were likely to have at least one of those chronic conditions in the subgroup eligible for subsidized insurance. Although somewhat counter-intuitive, we found the higher prevalence of reported chronic condition for the insured than for the uninsured is consistent with prior research findings that having chronic conditions was significantly associated with health insurance coverage and access to health care (Preisser et al., 1998) in the sense that persons with better access to health care have a greater likelihood of having their chronic conditions diagnosed. Disability status was not significantly associated with insurance status in either group.

Disparities in health care access and use between the insured and the uninsured were more apparent (Table 7). The insured were far more likely than the uninsured to have a regular provider (76% vs. 46% for those eligible for Medi-Cal, and 86% vs. 55% for those eligible for subsidized insurance). Similarly, the insured were much more likely to have visited a doctor in the past year than the uninsured in both incomes groups, with the differences being larger for those eligible for subsidized insurance (83% vs. 55%) than for those eligible for Medi-Cal (75% vs. 55%). In both groups, a somewhat higher proportion of the insured than the uninsured reported having visited emergency rooms in the past year. While some studies have found that persons without insurance or a usual source of care are disproportionately represented among patients visiting ERs (Jones et al., 1999; Newton et al., 2008), others have found that the uninsured are no more likely to use ERs than the insured (Irvin et al., 2003; Weber et al., 2005). The findings of the present study are consistent with the latter.

Disparities were also evident with regard to preventive care. The extent to which preventive care was used was consistently lower for the uninsured than for the insured in both income groups. For example, the uninsured were less likely than the insured to have received a flu shot in the past year. The uninsured were also less likely to have received colorectal cancer screening in compliance with the guidelines for adults 50 years or older. Among AA women ages 40 or older in both groups, the uninsured were less likely than the insured to have received a mammogram within the past two years than the uninsured. Similarly, the uninsured were less likely to have received Pap smear within the past two years than the insured in both groups.

While it is not apparent that chronic conditions or disability were significantly associated with insurance status in both income groups, health care use in several aspects (such as visiting a doctor, emergency rooms, and receiving preventive care) was significantly and consistently associated with insurance status in both target groups in a way to reduce the use of health care for the uninsured.

Predictors of Uninsurance

We fitted three multivariate logistic regression models to identify prominent predictors of insurance for AA small business owners and employees, while controlling for other potential predictors in the same models. In addition to an analysis using the entire AA sample, we also ran analyses stratified by nativity status to examine whether different factors predict insurance status for the foreign-born and the U.S.-born.

Presented in Table 8 are the results of these analyses. In the analysis using the entire AA sample, males were about 1.4 times more likely to be uninsured than females. Four-year college graduates were about 39% less likely to be uninsured than those without a four-year college. Foreign nativity was not significantly associated with insurance status in this model. With the Japanese (who had the highest insurance rate and the highest socioeconomic status among all AA ethnic groups) as the reference group, Koreans were about 6.8 times and South Asians about 2.3 times more likely to be uninsured. Compared to those with incomes over 400% of the FPL, those who would be eligible for Medi-Cal were

about 2.5 times more likely to be uninsured and those eligible for subsidized insurance were about 1.8 times more likely to be uninsured.

Table 8. Predictors of Uninsurance for AA Small Business Owners and Employees

Predictors	All Asian	US-born Asian	Foreign-born Asian
	AOR (95% CI)	AOR (95% CI)	AOR (95% CI)
	Model 1 (N=3319)	**Model 2** (N=658)	**Model 3** (N=2420)
Male	1.43**(1.04-2.00)	1.34(0.48-3.75)	1.44**(1.01-2.05)
Age	0.98***(0.97-0.99)	0.99(0.97-1.02)	0.98**(0.97-1.00)
4-year college degree +	0.61****(0.44-0.86)	0.45(0.133-1.54)	0.65**(0.44-0.96)
New Immigrants (<5 yrs)	-	-	2.51****(1.57-4.01)
Limited English proficiency	-	-	1.94****(1.35-2.80)
Foreign-born	1.09(0.64-1.83)	-	-
Chinese	1.74(0.83-3.66)	1.41(0.50-3.97)	2.55(0.79-8.15)
Korean	6.76****(3.21-14.23)	1.78(0.54-5.89)	11.88****(3.83-36.89)
Filipino	1.72(0.80-3.69)	1.11(0.38-3.27)	3.64**(1.09-12.17)
South Asian	2.29**(1.01-5.19)	1.79(0.37-8.65)	3.50**(1.02-11.98)
Vietnamese	1.95(0.74-5.14)	3.56(0.31-41.02)	2.43(0.73-8.15)
Southeast Asian	2.48*(0.95-6.43)	6.09**(1.24-29.92)	3.46 (0.83-14.39)
Eligible for Medi-Cal	2.48****(1.52-4.04)	5.07***(1.54-16.71)	1.68*(1.00-2.83)
Eligible for Subsidized Insurance	1.83***(1.27-2.63)	1.53(0.51-4.64)	1.74***(1.17-2.60)

Note: AOR: Adjusted odds ratio, CI: Confidence Interval; *p<.10, ** p <.05, ***p <.01, **** p <.001

Vietnamese were analyzed separately from other Southeast Asian groups – Cambodians, Hmong, and Laotians – because Vietnamese were over-sampled and could therefore provide reliable estimates. Other Southeast Asian groups had comparatively smaller sample sizes and were aggregated in the analyses as a result.

Albeit with some similarities, predictors of uninsurance somewhat differed, depending upon nativity status. Among the U.S.-born, Southeast Asians emerged as the ethnic group at the highest risk of being uninsured, being about 6.1 times as likely to be uninsured as the Japanese, the reference group. Those who would be eligible for Medi-Cal were about 5.1 times as likely to be uninsured as the higher-income group. Among foreign-born AA, Koreans were at higher risk of being insured than all the other AA ethnic groups, being almost 12 times more likely to be uninsured than the Japanese. Although the odds were lower, foreign-born Filipinos and South Asians were also at high risk of being uninsured, being about 3.6 times and 3.5 times more likely to be uninsured than the Japanese, respectively. Somewhat surprisingly, the odds of being uninsured were similar between those who would be eligible for subsidized insurance (1.74 times greater than the higher-income group) and those eligible for Medi-Cal (also about 1.68 times, significant at a higher level of p<.10). Other prominent predictors of uninsurance for the foreign-born included being a new immigrant who had lived in the U.S. for fewer than 5 years (with their odds of uninsurance being about 2.5 times greater than immigrants who had lived in the U.S. longer) and having LEP (associated with about 1.9 times odds of being uninsured compared to those without LEP).

QUALITATIVE RESEARCH FINDINGS: ANALYSIS OF FOCUS GROUPS

DEMOGRAPHIC PROFILE OF FOCUS GROUP PARTICIPANTS

We conducted nine focus groups (FGs) with a total of 68 participants comprised of employees and employers of small businesses among the Korean, Hmong, South Asian[2], Vietnamese, and Pacific Islander communities across California (Table 9). Geographically, the FGs were held in Northern (Sacramento and Alameda County), Central (Fresno county), and Southern (Los Angeles county) California. Female participants represented two-thirds of the sample, although gender distribution varied depending on the FG. Nearly one-third of the FG participants reported not having insurance coverage.

Table 9. Focus Group Demographics of Participants from Small Businesses

Focus Group Type	N	County	Ethnicity	Gender	Insured
Korean Employee	5	Los Angeles	Korean (5)	80% Female	*50% Insured
				20% Male	50% Uninsured
Korean Employer	7	Los Angeles	Korean (5)	14% Female	86% Insured
				86% Male	14% Uninsured
Hmong Employee	7	Fresno	Hmong (7)	86% Female	29% Insured
				14% Male	71% Uninsured
Hmong Employer	7	Fresno	Hmong (7)	0% Female	71% Insured
				100% Male	29% Uninsured
South Asian Employee	5	Los Angeles	Bangladeshi (3) Indian (1) Pakistani (1)	75% Female	50% Insured
				25% Male	50% Uninsured
South Asian Employer	6	Los Angeles	Nepalese (6)	67% Female	33% Insured
				33% Male	67% Uninsured
Vietnamese Employee	8	Alameda	Vietnamese (8)	100% Female	63% Insured
				0% Male	38% Uninsured
Vietnamese Employer	9	Alameda, Santa Clara	Vietnamese (9)	100% Female	*100% Insured
				0% Male	0% Uninsured
Pacific Islander Employer/ Employee	14	Sacramento	*Tongan (8) Fijian (2) Filipino (2) Samoan-Tahitian (1)	64% Female	71% Insured
				36% Male	29% Uninsured
Total	**68**			**66% Female** **34% Male**	**65% Insured** **35% Uninsured**

Note: Category is missing 1 response

2 *Bangladeshi, Indian, Nepalese, and Pakistani.*

ASSESSING HEALTH INSURANCE AND HEALTH CARE SERVICES

Current Sources of Health Insurance Coverage

The majority of participants across all focus groups (FGs) reported having some type of health insurance, but a substantial proportion of participants also said that they were uninsured. The primary sources of health insurance included employer, family member, privately-purchased insurance, Medi-Cal, or other government programs. Most participants from small business employee FGs said that they obtained insurance primarily through government programs such as Medi-Cal or were uninsured. Most participants from the small business employer FGs said that they were covered by an employer or a family member's plan; some reported obtaining a job while running their own businesses for the sole purpose of accessing employer-provided insurance. A few small business employee and owner participants across seven FGs also mentioned that they purchased private insurance or subscribed to discount programs with the assistance of ethnic community insurance brokers or community health centers. Participants also mentioned that they would be open to buying health insurance, if uninsured, or seeking more comprehensive coverage if there were low cost, comprehensive insurance options available to them from health plans or employers and if they received eligibility assistance and in-language support.

Employee Perspectives

Most of the participants who were employees of small businesses said that they had health insurance, many of whom were covered through Medi-Cal. Under Medi-Cal, participants were able to obtain medication and see a doctor at no cost. A large number of the participants also mentioned that they were uninsured and sought to care for their health without seeking actual health care. Some uninsured participants indicated that they would avoid seeking care until deemed absolutely necessary due to the prohibitive costs of treatment without insurance. A few participants also stated that they would consider paying out-of-pocket for care they really needed. Further, several mentioned that because they did not have insurance, they depended on the free health care provided by their local community health center.

> *"Since my children had been already covered by Medi-Cal, when I got diabetes, I applied for Medi-Cal. I got Medi-Cal. We didn't have any problems in getting it. This large Korean organization in L.A. helped me in applying for Medi-Cal. There was a Korean person who helped me."*
>
> *– Participant from Korean Employee FG*

> *"I am a widow too. I don't make much. So that is why I don't buy insurance, but I go to Asian Health Services [a local community health center] to be seen [by a doctor]."*
>
> *– Participant from Vietnamese Employee FG*

The majority of participants from employee FGs indicated that government insurance programs such as Medi-Cal and those provided by Veterans Health Administration were the main sources for obtaining insurance. These programs would cover their doctors' visits, treatment, and medications, if they were eligible for them. In addition to government programs, finding coverage through an insurance broker in their ethnic community or a family member were other ways in which individuals could obtain insurance. They stated that they could trust community brokers and family members, such as parents or children, for additional information and for purchasing health insurance.

"There weren't too many problems [with obtaining Medi-Cal]. The only problem that I had was that they told me that I wouldn't qualify because of my income. So I was really worried about that. Just because I make above the limit, doesn't mean that I am well off. I have a lot of bills that I have to pay for. So when they told me I was able to get it, I was very happy."

– Participant from Hmong Employee FG

"We used to have United Health Care. It got expensive and so we switched to Blue Cross. We've always had insurance. We've worked with a Korean broker. There was no difficulty in getting insurance."

– Participants from Korean Employee FG

Employer Perspectives

The majority of participants from the employer FGs were covered under a family member's health plan or purchased private insurance on their own. Many of them reported working for other employers who offered health insurance, while running their own small businesses, for the sole purpose of obtaining insurance. Those who had private insurance reported working with insurance brokers within their communities. Some reported subscribing to discounted programs which could reduce costs for emergency care or in-patient care.

"I took a job so that I would have an insurance provided by my employer. [I am a] silent owner, you know. So I have technicians and I have a manager who runs the nail salon. Having health insurance is important to me because I have preexisting [conditions]—I am a breast cancer survivor—so I need health insurance. So if I work full-time and manage my salon, then I would have to purchase insurance and it would be very expensive. Therefore I have to work full-time and hire a manager who runs the nail salon so I don't have to pay the extra, you know, money for my health insurance."

– Participant from Vietnamese Employer FG

For employer FG participants, family members were key sources for obtaining insurance. Many said that they had spouses who worked for an employer who would be able to provide comprehensive insurance coverage at a more affordable rate for the whole family. Some also mentioned that they had purchased or attempted to purchase private insurance, whether for oneself or for the whole family. In general, participants said from their personal experiences, purchasing individual insurance costs much more than purchasing through a family members' employer. A few participants also said that the insurance coverage was less comprehensive when one purchased individual private insurance. In summary, many mentioned that they preferred to get covered under a family members' plan, if they had the option to do so.

"As a self-employed person, I can't remember the last time I had insurance. I don't think that is, with Hmong parents as business owners, health insurance is not necessarily a top priority. And so I recently got health insurance after getting married. [Without my spouse's insurance,] I probably would still not have [insurance]."

– Participant from Hmong Employer FG

"Before I had the insurance from my job. I quit the job and after that I get insurance by myself, individual plan. Before I had it from my job and I use to pay 100 something for a single cover. I didn't pay anything when I went to the hospital. I paid 20 dollars co-pay but I didn't have to pay anything for that. After [I quit my job], I paid 300 something for the health plan only."

– Participant from South Asian Employer FG

Facilitators to Improving Current Insurance Coverage

Most participants across all employee and employer FGs expressed their interest in getting insurance, if uninsured, or getting more comprehensive coverage, if already insured. A majority of both employee and employer FG participants indicated that if health plans could provide low-cost, comprehensive insurance options, that would make insurance affordable and allow them to get the type of insurance they prefer.

Some participants who were small business employees insisted that small business owners should provide insurance. Participants also mentioned that receiving information about where to seek help with eligibility assistance and language assistance to facilitate the insurance application process would be helpful.

> *"It has to be affordable, first of all, and cover all her needs. Then we will go for it. But nobody is accepting her because she had the surgery."*
>
> *– Participant from South Asian Employee FG*

> *"Some pressure needs to be created by the government over the business owners that without health insurance you cannot have any employees. That will force them [owners] to help employees to buy or help them buy the insurance. Otherwise, they are not going to do. An example is vehicle insurance. You have to buy auto insurance. Otherwise you cannot drive. So something has to be mandatory. Otherwise employer will not take any initiatives. We will not get enough money to buy and of course working for small business owners, we are losing the other benefits to like no incremental bonuses."*
>
> *– Participant from South Asian Employee FG*

> *"I got Medi-Cal. We didn't have any problems in getting it. This large Korean organization in LA helped me to apply for Medi-Cal. There was a Korean person who helped me."*
>
> *– Participant from Korean Employee FG*

Barriers to Health Insurance Coverage

Participants in all the FGs mentioned a number of barriers they faced in obtaining health insurance coverage. High cost was the most significant barrier to obtaining insurance, followed by having a low income, and having pre-existing conditions. The major barriers for small business employee participants included financial hardship, the lack of employer-provided insurance, and prohibitively high costs of individual plans. These barriers were similar in terms of the cost considerations, but slightly different from the major barriers small business employer participants faced which included the high costs of health insurance for themselves and their family members and prioritizing everyday needs for their business and personal expenses.

Employee Perspectives

For small business employees, the major barriers to obtaining health insurance coverage were financial hardship due to low income, lack of employer-provided insurance, and high insurance costs that made it unaffordable for them to purchase health insurance. The majority of participants who worked for a small business mentioned they were currently experiencing a great financial hardship. Most participants made very low wages or were unemployed. Several were on social welfare, and others were being paid under-the-table. Some participants relayed how their meager savings disqualified them from accessing government programs such as Medi-Cal. With the little money they made, paying for basic necessities was the highest priority to them.

"We can't afford it [health insurance]. We have [an income of] $1,000 and they [the insurance] ask for $800. So should we buy insurance or should we survive? We work hard and try to save money. But when we applied for Medi-Cal, they said we had a little bit of savings. [So] we're disqualified."

– Participant from South Asian Employee FG

Most employee FG participants and a few employer participants also felt that their employers' lack of providing insurance benefits was another major barrier to getting insurance. Both employee and employer participants acknowledged that small businesses were often struggling; however, they felt that it also made many employers feel they were not obligated to provide insurance for their employees. A few employee participants mentioned attempting to ask for health insurance or a raise but were ignored by their employer or, worse yet, recommended to find another job. Employee participants who were paid under the table were especially reluctant to talk to their employers about health insurance. One participant who was paid under the table expressed concerns that her unemployment benefits would be much less than she was entitled to as her reported earnings were smaller than her actual earnings. Though unrelated to health insurance directly, the fact that some small business employers often refused to pay their employees legally to reduce their payroll taxes or other related costs was an indication of how they would be even more reluctant to incur higher costs by providing insurance to their employees.

"In case I'm unable to work, if I ask the government to help for public assistance, I will get public assistance based on what I contributed to the government. So if I lose my job and ask for the public assistance, like unemployment, I will get very little. According to government's record, I earn very little. They [the owners] don't want to show the government that they pay me $2,000 dollars because if my contribution increases, then their contribution increases too."

– Participant from South Asian Employee FG

Given the employer reluctance to provide insurance, an alternative was for employees to purchase private insurance on their own. However, high insurance costs prevented many of the uninsured participants from obtaining insurance or even seeking information about insurance coverage. Most said that they could not afford the extra expense to purchase health insurance. Several uninsured participants knew that they were not able to afford private insurance, so they would not even consider seeking more information about it.

"…my biggest concern is the money, because I have to pay off loans. I also have to pay for gas, to pay for travel. That adds an extra burden on me. Like most people, if I don't have to pay for it, I am not going to pay for it. I am young and supposedly healthy."

– Participant from Hmong Employee FG

One participant from the South Asian FG had a pre-existing condition which kept affordable insurance out of her reach. With no insurance, a few employee participants said that all they could do was to avoid seeking health care and pray to stay healthy. When they were in urgent need of health care, some participants said they would just have to go to the emergency room or pay out of pocket for doctor visits.

"People just don't know what is out there … we have people who have passed [away] due to complications from high blood pressure, cancer. You know, when you think about it, we could have been provided services. But instead, [because of] the lack of knowledge, you know, so they don't have access. [The services] might [have] been available in Sacramento. It is just a matter of getting the information to people so they can actually know."

– Participant from Pacific Islander FG

Employer Perspectives

The most significant barriers for small business employers in getting insurance were the high costs of health insurance for themselves and their families and their prioritizing business and personal expenses. Most participants felt that the costs for comprehensive insurance to cover themselves and their family members were too high. Many of them said that they or one of their family members had pre-existing conditions and the revenue they made from their business was not enough to cover the insurance costs for everyone. At the same time, because their incomes also disqualified them from accessing most public insurance such as Medi-Cal, some participants opted to purchase private insurance packages that offered partial or limited coverage for them and/or their families. Some participants also said they would purchase insurance for only family members who really needed it.

> *"I have a daughter. She's over 26 [years old]. She works but she couldn't get it [insurance] through her employer. When she goes to try to get insurance, she has pre-existing conditions so she was denied. So it's hard. How do you get around it? You try to get medical insurance because it becomes diabetes, whatever. But they denied [you] because you already had it."*
>
> *– Participant from Pacific Islander FG*

For other employer participants, paying high insurance premiums monthly was not a high priority in comparison to the cost to support their business and other daily expenses. Another participant said that the insurance cost was so high in relation to their monthly salary that they were scared to think about it. As indicated by a participant, such fear led them to not even want to seek information about insurance options until something severe actually happened to their health and they were forced to face it.

> *"For young business owners, I can say for myself, this is not a priority. So if it's not in front of us all the time… health is very important but health insurance on a business level is very low on the priority list, especially with the cost and the fear of the cost [and] not even having the information."*
>
> *– Participant from Hmong Employer FG*

> *"Insurance is so expensive and people cannot afford it. Somebody said that the monthly premium was $2,000. When you don't even make $2,000, it's hard to pay $2,000 in premium."*
>
> *– Participant from Korean Employer FG*

Perceptions about Health Insurance Costs and Affordability

Most participants of both small business employee and employer FGs shared a general perception that health insurance, particularly private individual plans, was expensive and not affordable for themselves and their family members. Many participants also felt that insurance provided through a family member's employer was most affordable and comprehensive.

Employee Perspectives

Most employee FG participants perceived that, with the exceptions of government programs like Medi-Cal, health insurance was too expensive. The majority of uninsured employee FG participants indicated that private insurance was too expensive and not affordable because of their low income. With the small amount of money they had, they prioritized paying for living costs over health insurance costs. For those who worked for employers that provided health insurance, they said that insurance costs, such as monthly premiums, could vary based on your employer and the type of plan that was offered.

"I'm getting $1,500 dollars per month. $1,200 dollars I have to pay for rent. With $300 dollars, what can [I] do? My husband was working. But 3 years ago, the company went to China. He's jobless [now]. He's been jobless during the last 3 years. And it is very hard to survive. So how can we afford insurance? I have so many health problems, skin problem, coughing, and a lot of things, but [I] can't do [anything about it]."

– Participant from South Asian Employee FG

Employer Perspectives

The majority of small business employer FG participants also perceived that health insurance costs were too high for them. Just like participants who were employees, participants who owned small businesses felt that purchasing private insurance was very expensive. Most employer participants said that private insurance often times came with high monthly premiums and high deductibles. Even with the private insurance, some participants felt that they had to essentially pay for everything: doctors' visits, screenings, and treatment. To avoid paying for high premiums while still having some form of coverage, some participants chose to purchase partial or selective coverage or discount plans to reduce the costs of more resource-intensive emergency or in-patient care or to cover certain needed treatments. Some also mentioned purchasing insurance to cover family members who needed it more, leaving the rest uninsured. While most employer participants perceived the cost of insurance to be expensive when purchased privately, many participants felt insurance provided through a family member's employer was affordable, as the premiums and co-payments were lower. Comprehensive coverage was another distinctive advantage of such plans.

Barriers and Facilitators related to Undocumented Immigrant Status

The majority of both employee and employer FG participants across all FGs said that they were aware of the barriers to accessing health insurance and health care for individuals who were recent, undocumented immigrants or have mixed-status families, but most across employee and employer groups said they had not heard much about specific problems such immigrants faced. Select participants across seven FGs (employee and employer) said that individuals who were undocumented were often too scared to seek health insurance and medical treatment due to fear of deportation. Some had heard of individuals trying to apply for Medi-Cal, but that many were denied. If treatment was urgently needed, a number of them said that the undocumented immigrants they knew of or heard about would seek care in the emergency room and have to pay the bill out-of-pocket; otherwise they would wait and hope that their condition would get better or seek help through traditional health practices.

Undocumented status was a topic that participants in the Pacific Islander FG talked about much more than in the other FGs. One example about undocumented immigrants that was brought up in the Pacific Islander FG was an undocumented and uninsured Pacific Islander immigrant who had a cancerous growth spreading throughout her body. She was not able to go anywhere to seek care when she first discovered her condition because she did not have health insurance or legal status and her condition consequently worsened.

"I know this one woman in Sacramento. Her stomach is way out here. She refuses to go anywhere for help because she doesn't have any papers. She's scared to death. Now she has a growth on her back and it's really been sad. It's sad. They tried to get Medicaid. They turn to their cultural medication, a lot of which are less chemical anyway."

– Participant from Pacific Islander FG

A few FG participants in the Pacific Islander, Korean, and Hmong FGs said that for families who had mixed status where the parents were undocumented and the children were not, there was likely constant anxiety and a sense of hopelessness. Some participants also said that often times children in mixed-status families were able to obtain aid from government programs. However, many children and parents in mixed-status families would not seek health care for fear of deportation.

> *"It depends. When children of undocumented folks get sick, it depends on how sick they are. If the sickness is minor, they will take care of themselves. If it involves an emergency room, it does not matter if they are undocumented as they will always be treated."*
>
> *– Participant from Korean Employer FG*

Several participants also mentioned resources that could help undocumented individuals to access temporary insurance coverage and treatment. Most of those resources mentioned were county funded programs or other safety net programs that could cover up to a certain number of visits or partially pay for treatment for a limited length of time.

> *"The County has a program to help them with the medication and their treatment. It's called [program name]. You can go to the one on Broadway [Street], the county office there, sign up with them and they'll give it to you. It's limited for like 3 months/6 months; you have to renew it. But the county does have provision for those that do not have legal documents."*
>
> *– Participant from Pacific Islander FG*

Small Business Employer Barriers and Information Needs to Providing Employees Insurance

The primary barrier to providing employee insurance mentioned by all employer FG participants was the high costs of insurance, the lack of coordination between employers and employees for sharing the cost burden, the inadequate subsidies to support small businesses, and the new requirements to small business employers to provide insurance coverage to their employees.

Most small business employer participants said that their business revenues were too low and were not even able to afford purchasing insurance for themselves. Many employee FG participants stated that buying insurance for employees was not viable and an extremely costly expense for their businesses as the small number of employees they had would leave them ineligible for the discounts or subsidies often available to larger employers. One employer participant commented that the cost for providing health insurance to their employees would be similar to purchasing private individual plans.

> *"We went with HealthNet … we went with Blue Cross and all that. And then basically Kaiser was the other big one … but then a while back, we had 4 employees that we all paid for through the company. It didn't really matter if you went through a company or you had one or two employees. It was pretty much the same rate. So, [be]cause I remember paying for about 4 of the people and it was pretty much the same rate."*
>
> *– Participant from Hmong Employer FG*

Some employer participants were doubtful that they could provide health insurance to their employees even with the new ACA provisions that offer subsidized insurance, because they believed that subsidies for small businesses would be distributed based on the number of employees one has and that they would not be eligible for them given the small size of their workforce. Specific to the Hmong employer FG in the Central Valley, participants brought up that the limited number of insurance companies and lack of competition in their rural region also contributed to the high insurance costs.

In addition to the affordability to provide health insurance to employees, many participants relayed how anxious they were when they heard about the new ACA requirements for small businesses to provide insurance to their employees and the lack of specific information they had about these requirements. Participants mentioned they did not have adequate information about how much purchasing the health insurance for their employees in the new marketplace would cost, and what the penalty would be if small business employers did not complete with the new requirements.

Some participants saw the need for the dissemination of this information to small business employers like themselves as soon as possible in order for them to be able to understand the new requirements and the steps they needed to take to comply with them. They also indicated that they needed someone familiar with the ACA requirements to provide relevant information to employers and to get employers to start talking to their employees about the upcoming changes. Also, this information would allow them to be able to better assess whether they could and will need to provide insurance to their employees. Unless this information was brought to the employers' attention in a timely fashion and through trusted individuals such as family members or a professional like a CPA or a lawyer from their communities, these employer participants said that they would not see it as a priority and would not likely comply with the new ACA requirements for employers.

As indicated by some employer FG participants, one of the main facilitators that could induce them to provide insurance to their employees was to have their employees contribute to covering part of the insurance cost. This would lessen the burden for employers and likely render them more willing to provide insurance. Several employer participants said that they had attempted to approach their employees with this idea but their employees had refused to share costs.

> *"Well, so far, I don't know. I don't know about the law. And then the second thing is I don't think I can afford to do it. But I share his, if we could half and half, if my employees are willing to do that, maybe I can look into that."*
>
> *– Participant from Pacific Islander FG*

> *"Yeah, it all depends. But they definitely skip out on it. So going back to cost, it's too expensive. I mean we offer [it] but we are not going to pay whole thing. We're just going to help pay a percentage and it still slipped out. We didn't have enough employees to say yes … to get their minimum. So it just went out the door."*
>
> *– Participant from Hmong Employer FG*

Experiences in Health Care Access

Most participants mentioned that they had experienced barriers to accessing health care. The main barriers the FG participants reported included the cost burden of heath care, their prioritizing work and daily life needs over accessing health care, and transportation barriers to health care.

In six out of the nine FGs, both employee and employer FG participants discussed the high costs associated with accessing health care. Many of the participants felt that health care had not only become too expensive to pay for but that the payment process was unclear and confusing.

> *"... Obama needs to change the billing process and charges. We patients have no idea what services will be provided and how much they will cost ahead of time. Providers should inform patients of the costs ahead of time and get the patient's signature [i.e., consent] before they proceed. I was at an emergency room overnight and the bill came out to be $20,000."*
>
> *– Participant from Korean Employer FG*

> *"… with health insurance, there are a lot of surprises, like there's too much detail. I was expecting to get some dental work done. Then I get a big bill and I thought I was covered. Then they say if I look at my policy, but there are pages of policy. It's almost like a lack of trust."*
>
> *– Participant from Pacific Islander FG*

Participants often discussed the high costs of health care despite the seemingly limited health care services they received. A wide range of health services ranging from preventive care to urgent care and including both out-patient and in-patient care were discussed and considered to be unreasonably expensive by participants.

In addition to high costs, access-related barriers were also mentioned. This was a frequent topic of discussion in the South Asian Employee FG and, to a lesser degree, in the Pacific Islander FG. Participants discussed the physical challenges involved in having to travel to health care facilities. A participant discussed the value of being able to use public transportation to visit a nearby health care facility, while another mentioned that many recent immigrants do not have access to a car and therefore cannot travel far.

> *"Transportation is important. We cannot go too far. It would be convenient if we had some facility within 10 mile radius, using public transportation would be good."*
>
> *– Participant from South Asian Employee FG*

Another challenge in seeking health care services involved having to take time off work. One participant discussed the need to prioritize work over seeing a doctor regarding an illness. Under such circumstances, delaying care was often considered necessary.

> *"… three months [ago], I got a fever. But still I've got to go to work. Without work, I can't survive."*
>
> *– Participant from South Asian Employee FG*

A participant from the South Asian Employee FG also discussed the competing demands of work and seeking medical attention. The participant's husband was unemployed, thereby making day-to-day living extremely difficult; with the little income that was available, visiting a doctor was not considered a necessity.

Medi-Cal

Participants from FGs felt that Medi-Cal can be both very helpful and unhelpful. A higher number of FGs involved a discussion of the benefits of Medi-Cal; however, discussions of how Medi-Cal could be challenging occurred much more frequently across FGs. The primary challenges often mentioned included the difficulty of accessing the health care they needed through Medi-Cal, the lack of consistency in care from the same providers and with receiving in-language assistance, and the stringent eligibility criteria for Medi-Cal. As reported by some participants, comprehensive coverage and little or no costs for health services were important strengths of Medi-Cal. In-language assistance was another strength mentioned by some participants who had been able to access it. .

The most frequent issue discussed was the inconvenience of accessing health care through Medi-Cal, which was too burdensome for several participants. One of the major inconveniences was the vast amount of paperwork and frequent visits to Medi-Cal offices required, which was also considered to be confusing.

> *"It takes a lot of office visits. There's a lot of pushing forms to try to get it. If you fill out something wrong, then [you] go back and [do it] all over again ..."*
>
> *– Participant from Pacific Islander FG*

> *"But you know it's not clear. Because when they go to the welfare office, even one form and they fill it out and that's supposed to be getting information about Medi-Cal/ Medicare or whatever else. It's all unclear, the system right now. People have to get up at 5am in the morning to be seen at 10 o'clock. And in a few minutes, a tick or what, come back tomorrow."*
>
> *– Participant from Pacific Islander FG*

As noted by one participant from the Vietnamese Employee FG, the confusion was exacerbated by the different case workers that may change year to year. Without a regular case worker, information about and the specific Medi-Cal recipient was often lost on the case worker, forcing the recipient to repeat the cumbersome processes.

> *"I think I have problems with Medi-Cal. The paperwork and the requirements on Medi-Cal workers are too much, especially when we don't have the same [case] workers every year. Sometimes they change every year. This year I have one worker who in [charge] of my Medi-Cal and next year I have another one. Every new worker requires paper[work]. And then, it is like endless [amount] of paper[work]."*
>
> *– Participant from Vietnamese Employee FG*

Another frequent complaint was the stringent eligibility criteria for Medi-Cal. Especially in the Pacific Islander FG, but also in the Hmong and South Asian Employee FGs, participants felt that the income requirements were unreasonably low. Participants who were ineligible or barely eligible commonly indicated that even when they appeared to have sufficient incomes or savings to disqualify them from accessing Medi-Cal, the reality was that a significant portion of income would be spent to pay for basic necessities, leaving them very little left to pay for health care.

"The only problem that I had was that they told me that I wouldn't qualify because of my income. So I was really worried about that. Just because I make above the limit, doesn't mean that I am well off. I have a lot of bills that I have to pay for. So when they told me I was able to get it, I was very happy."

– Participant from Hmong Employee FG

"Because we can't afford it. We have [an income of] $1000 and they [the insurance] ask for $800. So should we buy insurance or should we survive? We work hard and try to save money. But when we applied for Medi-Cal, they say we have a little bit of savings. [So] we're disqualified."

– Participant from South Asian Employee FG

Not all participants complained about Medi-Cal, however. A few participants spoke highly of the program. The greatest benefit of Medi-Cal appeared to be the wide range of health care services it provided. Participants from employee FGs indicated that Medi-Cal allowed them to visit their health care provider whenever needed, purchase medication, and receive culturally competent care, while having to pay little or nothing for the services they received.

"We can see the doctor. We can buy the medication. They [the optometrist] can check up on the eyes. I mean for anything. It is really a big help for us. Thank you so much."

– Participant from Vietnamese Employee FG

"I can see the doctor. I can get the medicine. And when I am sick, I don't have to worry anymore. I can just go the doctor."

– Participant from Vietnamese Employee FG

What may make a difference in FG participants' experiences with Medi-Cal was the availability of cultural competency or the lack thereof. Two participants from the Korean Employee FG shared opposite views. A participant who had received in-language assistance had no challenges in accessing Medi-Cal, while the other participant reported the barriers she experienced, which came from the lack of in-language assistance.

"I didn't have any problem because I worked with a Korean social worker."

– Participant from Korean Employee FG

"In the past, the paperwork was too complicated. A lot of documents were needed, and there was no Korean speaking social worker to help Koreans."

– Participant from Korean Employee FG

Seeking Alternative Health Care Abroad

Because of the high costs and dissatisfaction with health care in the US, several participants reported having sought health care abroad. Participants from the Pacific Islander, Korean, and South Asian Employee FGs relayed how the various barriers to health care, particularly high costs and difficulty with navigating the healthcare system, forced them or other members of their community to travel to other countries, mostly their homelands, to receive care.

"Many Koreans are finding that they can get insurance in Korea – if you live for three months in Korea. So many are choosing that option. You just need to get a document from the LA Consulate that you are a resident here. Even US citizens go with that option."

– Participant from Korean Employee FG

"I've [sought] treatment in India twice. I like how the medical system and the treatments work there [in India]. I don't have much idea about this [new health care law], but I've heard that it's pretty expensive here. I'm concerned about affordable health insurance. She [my wife] had multiple medical conditions, but she is not seeing any doctor, or getting any therapy that she needs done and follow-up. Everything has been halted for the last two years because of the health insurance."
– Participant from South Asian Employee FG

It appears that the confusion around how to navigate the health care system also contributed to this practice. Some participants compared the quality of care abroad with that of the US and indicated that accessing quality health care is much easier and more feasible in other countries.

THE PATIENT PROTECTION AND AFFORDABLE CARE ACT IMPLEMENTATION

Most FG participants across the groups had heard about ACA implementation, but few knew about its provisions or incentives that may apply to them or the Covered California website, the state's insurance market place. The shrouded mystery around the ACA implementation undermined many participants' support for ACA's health care coverage expansion and its programs. While the Covered California website is a convenient way to access information and sign up for insurance, this web-based approach to access also deepens the technological divide between the younger and potentially more advantaged segments of AA communities and those who are more disadvantaged. This section summarizes the key findings about participants' knowledge and perspectives about the ACA provisions that may affect them (e.g., subsidized insurance, Medi-Cal expansion, and tax credits for small business employers providing insurance) and the Covered California website as a one-stop shop where users can obtain information or sign up for insurance.

Awareness and Perceptions about the ACA

The majority of participants across all the FGs indicated they were not well informed about the new ACA provisions. Many of the participants had heard about the coverage expansion, that businesses would be affected and insurance costs would increase. However, the majority of participants were unfamiliar with the specifics of what the incentives entailed, how small businesses would be affected, what the actual costs would be, and how the law was going to be implemented. Some participants also said that they did not have any information on the new law.

At the same time, in both employee and employer FGs, participant perceptions of the ACA provisions were mixed, some positive and some negative. Many of them also expressed anxiety coming from the uncertainty and/or confusion about how ACA implementation would affect them. The main reasons for the participants' negative view of the ACA included the concerns about the high cost of health care under the new system, concerns about people who may take advantage of the system by finding loopholes, and doubts about the implementation. Many participants also felt uncertain about how the implementation would affect small businesses. However, many also expressed that the uncertainty and anxiety they felt was due to lack of outreach about the ACA and its implementation.

Employee Perspectives

The majority of FG participants who were small business employees expressed a lack of familiarity regarding ACA provisions and a strong interest in learning more about the ACA and its incentives. Most of the questions FG participants raised revolved around subsidized insurance. Participants felt unsure about whether the subsidies would be sufficient to make insurance affordable for them. They had

several questions about the eligibility provisions such as what constituted a household, an important consideration related to the income levels associated with the eligibility for subsidized insurance and Medi-Cal. There were also concerns about the quality of care and whether it would be different for people in different income brackets. Some participants also wanted more information regarding the Medi-Cal expansion, specifically what benefits it would offer and the new eligibility criteria for Medi-Cal under ACA. Despite wanting more detailed information, many participants indicated they had heard about coverage expansion under the ACA. Most had heard about the mandate that requires everyone to have insurance. Some had heard that those without insurance would pay a fine. Some participants also said they had heard more people would now qualify for public insurance like Medi-Cal. However, many participants felt that they needed more detailed information about the cost and how to obtain the insurance.

"The range of incomes for the family of the same size is very large. I am wondering if there are differences in premiums or subsidies, depending upon the income. We already pay a lot in taxes and if we are forced to get insurance, we won't be able to pay bills."

– Participant from Korean Employee FG

"If we qualify for Medi-Cal, would we be eligible for dental care, vision, and others?"

– Participant from South Asian Employee FG

"I've heard that the President is making people, every single one, to have to be covered by certain insurance. But how to buy, what price is, and if I can afford or not, I don't know."

– Participant from Vietnamese Employee FG

The majority of small business employees who participated in our FGs felt positive about the ACA provisions. Most participants expressed support for the coverage expansion in that it would ensure everyone can have health insurance. Some also expressed excitement about the new changes to be implemented. However, there were also many participants who felt confused or uncertain about the ACA provisions. The uncertainty for employees was mainly related to the lack of outreach regarding the ACA and its implementation. Participants felt that the implementation was soon approaching and yet there was little information provided to the communities in need. Some of the participants also expressed doubts about the implementation and wondered whether the reality would remain the same when the new law was implemented.

"Even if some people have to buy, I feel more confident with this table [that includes the information about the income levels related to the eligibility for subsidized insurance or Medi-Cal] because I know this information. Even if my family, friends or family, are not eligible for Medi-Cal, using this table, I [know I] am eligible to buy this under the government insurance program."

– Participant from Vietnamese Employee FG

"I'm so confused. It's like a big elephant that's so complicated and I don't even know where to start. And I don't know where to go. Who will break it down simply ABCDE for me or for the person on the street? Like working for a hospital, they talk about their revenues being impacted, so much less revenue, when they make these changes. Then I hear on the other side about the exchange, selling on behalf of the state or county or whatever. And yet it's right here at our doorstep. I heard it's like 8,000 pages long. I need somebody that I can trust that come say, "This is what it means." Maybe that's what would help. Shed some light."

– Participant from Pacific Islander FG

Employer Perspectives

Acknowledging that they were not familiar with the ACA provisions for small businesses, the majority of employer FG participants expressed a strong interest in learning about how small businesses would be affected by the ACA. Their main concerns were the potential financial impact on them as a result of the ACA. Some participants felt that the ACA unfairly targeted small business owners, creating an extra burden on their struggling businesses. They suggested that information regarding the costs of providing insurance to employees and information on any discounts on insurance plans should be disclosed. Most participants also felt that they were not well informed about the profile of businesses (e.g., the number or types of employees they employ) mandated to provide insurance. As was the case for the participants from the employee FGs, many had heard about the coverage expansion to those who had low income or were uninsured.

> *"What I know is from now on, with the health care act, as an employer I am supposed to buy health insurance for employees if they are full time. If I pay them by check then that means they work full time. I did call people who provide insurance in this area. And they told me there is still no exact news about that yet. So I am worried. If that is the law, and I cannot afford it right now, what can I do? I did bring this up with my employees and asked them that in case I could provide it for them, so, how many percent they could chip in … and they said no. So that is why I am very worried."*
>
> *– Participant from Vietnamese Employer FG*

> *"You got to have some kind of, like, a website, or some flyers like pamphlets [that says] this law concerns this kind of small business, based on the number of employees, what's required of you. If you don't do it, this is what you're going to pay. Hopefully, this will get the guy's attention. For small business like us, if we gotta buy insurance, we would rather spend that money and hire someone so they can feed their family. That's what we see."*
>
> *– Participant from Hmong Employer FG*

> *"[It's] supposed to cover more Americans. More people get covered. Some people will pay more so the people who never had it [insurance] before will get covered."*
>
> *– Participant from Pacific Islander FG*

The majority of small business owner participants had a negative perception of the ACA provisions, mainly because they felt that small-business owners would bear too much burden under the new provisions. Participants indicated that, unlike large corporations, small-business owners were often struggling to manage their businesses. The mandate for small businesses to provide insurance was an extraneous cost to them. Participants also felt unfairly targeted by the new health care law. In addition to the cost burden, many participants also felt that some people would take advantage of the ACA. Many felt that the ACA regulations would drive owners to find loopholes, such as paying employees less or decreasing the number of positions available, and corrupt the system. Some felt that there would be fraudulent cases by those who made money under-the-table. A few participants also felt that key players such as doctors, hospitals, insurance companies, and politicians would continue to gain from this new system.

> *"If the burden is shared with the entire industry, it would seem fair and even if you have to assume some costs you may not mind much. But that doesn't seem to be the case. It seems that only small business owners bear the burden. The question then is, is it a good law?"*
>
> *– Participants from Korean Employer FG*

"So it just becomes a corruption and at the end, it hurts the employee. Because the employers can't afford so they got to do what they do. And they are getting less now. So instead of having 60 people working full time, I'm going to have hire 120 people and put everybody on part-time. Even companies are doing that as we speak and then you don't qualify for the insurance and you make less."
– Participants from Hmong Employer FG

ACA Subsidies and Other Incentives

Overall, the majority of participants focused on the subsidies specific to Medi-Cal expansion. Among these participants, there were more who felt the Medi-Cal expansion was going to be positive. In addition to talking about Medi-Cal expansion, most of the participants also discussed subsidized insurance. Many participants talked about the uncertainty they felt about how the subsidized insurance would help achieve cost savings and improve the quality of care. However, there were still a number of participants who felt the subsidized insurance program would be a small help to them in obtaining insurance.

Employee Perspectives

For participants who were employees of small businesses, the majority of the discussion focused on subsidized insurance. While the feelings were mixed about the program, of the majority of participants that felt the program would not help them. The main concerns of FG participants who did not feel that the subsidized insurance would help were that their incomes were too low to allow them to purchase any type of insurance. Several participants from the Vietnamese FG said that they would rather continue to seek health care from their safety net community clinics, as opposed to purchasing insurance. The participants who indicated that the subsidized insurance would help felt positive that people of all income brackets would be able to have some type of insurance.

Medi-Cal expansion was another topic participants discussed at length. The majority felt the Medi-Cal expansion would be helpful in obtaining health insurance. Many of them felt that their income levels would make them eligible for Medi-Cal. Some also expressed that there is security with knowing there is some type of plan available to cover their insurance costs.

"Yeah, especially with the clients that we serve. I don't know about the community that you guys work with, what they fall under. But definitely most of the clients that we serve, a lot of them will fall under the Medi-Cal."

– Participant from Hmong Employee FG

However, some participants indicated that Medi-Cal expansion would not be helpful, expressing concerns that they may not be eligible for Medi-Cal given the low income threshold that determined Medi-Cal eligibility. A few participants also felt that the income eligibility would motivate some employees to work less or to be paid under-the-table to maintain their eligibility for Medi-Cal. There were also a couple of participants who talked about rumors of decreasing numbers of physicians accepting Medi-Cal and limits on Medi-Cal benefits. They were concerned about whether the system is ready to provide adequate care for its new members.

"The income limit that makes you eligible for Medi-Cal is too low. For a single person who makes $15,000 a year in gross income, how much do you think the net income is? How much do you think renting a one-bedroom apartment around here? Over $1,000. Even old ladies who are on welfare get $850 a month."

– Participant from Korean Employee FG

Employer Perspectives

The majority of participants in employer FGs also discussed Medi-Cal expansion. Participants were divided between those who perceived the expansion to be helpful and those who did not. Some participants felt that the expansion would be helpful for allowing people such as their employees or people who have low incomes to obtain insurance. Others felt that the expansion would not help them obtain insurance. A predominant reason being the eligibility bracket for Medi-Cal is too low. In discussing subsidized insurance, the majority of participants were uncertain about the program. Many had questions about how the cost would be determined, especially since the eligibility brackets were wide. It was unclear to them whether the cost of insurance under the subsidized program would be cheaper or the quality of care would be any different than what they already had. Several participants also wanted to get more specific information about eligibility, for example, what income or who in a household would be counted. A few participants were not sure why small business employers would be asked to provide insurance if this subsidized insurance provision and the Medi-Cal expansion would cover all range of incomes. A participant said that the laws would end up countering each other.

In terms of tax credits, there was not a lot of discussion generated. Many participants felt that the tax credits would not be helpful, as tax credits would not be able to offset the cost of providing insurance to employees. Some participants also said that they might not be eligible for tax credits, even if they provided insurance because their employees were often their family members. For the few who felt that the tax credit would be helpful, it still would not be sufficient to offset the financial burden of having to provide insurance to employees.

> *"But subsidized means how much a month? Price? Money is everything … So it is the same type of insurance. But if my income is higher than hers, then I have to pay more than her? Pay more, right?"*
> *– Participant from Vietnamese Employer FG*

> *"There's really no chance of us having any major injuries at all. We really don't have anything that cuts. The only thing that we handle is probably a scissor. There's really no chemical. We just have the one chemical and that's about it. That'll be all. Just having health insurance for one person is more troublesome [be]cause for most of us, it's family business. Most of us, our families are working there. So we wouldn't get the tax credits anyways. It's really not helpful at all."*
> *– Participant from South Asian Employer FG*

Is Covered California Website Useful?

The majority of first-generation immigrants (i.e., those who immigrated to the U.S. as an adult) did not find the website as a helpful medium to obtain information and sign up for health insurance in large part because of their unfamiliarity with using the computer. They also felt that they would need language assistance. The website would not have human interface and would not be able to explain complicated information to them. At the same time, some participants – the younger who were computer- or web-savvy – felt that the website would be helpful and convenient.

Twice as many participants from employee FGs as those from employer FGs reported unfamiliarity with using the computer. In addition, more participants from the employee FGs than those from the employer FGs felt that they would need language assistance. However, much of this difference may be a function of the generational divide than employment status. All of the employers (mostly Hmong and Nepali) who found a website useful were young and computer-savvy, whereas Vietnamese, Korean, and Pacific Islander employers who tended to be older and first-generation immigrants expressed concerns

that the website as a one-stop shop would pose barriers for most in their communities, with some of them acknowledging that the computer would be an appropriate means for the younger generation to obtain information.

The barriers perceived by first-generation immigrants were of multiple dimensions, involving English language proficiency, the ability to understand information provided on the website, and computer literacy, all of which are needed to navigate the website.

Language barriers appeared to be the paramount concern. In most FGs, the mention of the website as a one-stop shop to access information and purchase insurance immediately provoked comments concerning the language barrier it was likely to pose:

> *"Language is a barrier." – Participant from Pacific Islander FG*

> *"We need to have a website in Korean." – Participant from Korean Employee FG*

Difficulties in understanding what they assumed would be highly technical information provided on such a website were also perceived to be daunting. As two participants of the Pacific Islander FG stated, information on health insurance was "too much even for people who read and speak English," which "a community member who does not work in the medical field" would have trouble grasping. Furthermore, the inability to process such information was perceived to be fraught with peril which, as participants in several FGs indicated, appeared to raise "fear." Such fear, characterized as "the fear of the unknown" by a participant in the Pacific Islander FG, comes in part from not knowing what is buried in the fine print.

> *"There might be some things hidden … you will never know what's going to happen until you actually have to claim the insurance."*
>
> *– Participant from Pacific Islander FG*

A participant gave her experience of receiving unexpected bills after using health services, which she had assumed to be covered, as a ground for such "fear."

> *"With health insurance, there are a lot of surprises… there's too much information…I got some dental work done. Then I got a big bill for what I had thought was covered."*
>
> *– Participant from South Asian Employer FG*

Access to a computer and computer literacy are evident prerequisites for accessing information on Covered California's website. However, for many FG participants, navigating the Internet is not a skill everyone has, a computer is not always accessible, and obtaining a computer would inevitably involve an extra expense that they may not be able to afford.

> *"For those people who use a computer, who have an access to a computer. I don't know if everyone knows how to maneuver around the computer. I know some people who don't even like computers."*
>
> *– Participant from Pacific Islander FG*

Though few, some participants also pointed out the inherent inequity involved in such a requirement, sharing the perspectives of low-income community members with fewer means:

> *"We have to buy a computer [first]. Then we have to learn [how to use it]. We can't afford to. It's unfair."*
>
> *– Participant from South Asian Employee FG*

A few participants also felt that the website would lack human interface; having an office or a phone number that people could call and interact with would be helpful.

> *"It's a good resource to have, but at least for some people they're still going to need a person to interact with. So I'm not sure with the website, that's going to be provided too."*
>
> *– Participant from Hmong Employer FG*

In contrast, younger participants, most of whom were employers, indicated using a website would be a convenient way for individuals to access all the information in one place and to sign up for insurance. Unlike meetings or brochures where they would have to physically spend time to attend, the Internet would allow individuals to be able to look at information online whenever they wanted.

> *"Website is the easiest. Most of them would go online look it up themselves and see what it is and use it. It will be easier. Because for everybody it's easier to access the internet than to look for brochures or have somebody tell them. Most people cannot bring the time to come to some sort of meeting and understand it. I think most of us here don't have the time. But if it's on a website, it's available whenever we want to look at it. Whenever we have a small amount of time to look at options, it's easier online. Everything is on the internet nowadays."*
>
> *– Participant from South Asian Employer FG*

Preferred Sources of Information

While younger and presumably Internet-savvy family members were reported to be important sources of information, the majority of participants preferred to receive information through community outreach or community-based education initiatives. Such community outreach or education efforts will need to involve publicizing the Covered California website itself, an important source of information few participants knew about. Outreach methods preferred by community members included community events, education training, and student groups. Aside from outreach, many participants preferred obtaining information from a trusted organization such as a community- or faith-based organization. Some participants also expressed interest in receiving information through the ethnic media such as newspaper/magazine, radio, and television. Having a source of information that also allowed interpersonal interaction was also important to them. One such example included a hotline provided by government agency. Lastly, sources of information available on the Internet, such as the Covered California website were preferred by younger members of AA communities. Whoever is involved in outreach and education – be they younger family members, CBOs, or the media – it would be critical for them to be well-trained enough to provide accurate information and adequate assistance, as indicated by participants in most FGs. A few participants stated that the health care-related information that needed to be provided should go beyond basic technical information to help establish the legitimacy of the new health care system, as the new health care law has been met with suspicion in some segments of the community, particularly among small business owners.

A generational divide was evident in specifying the preferred sources of information: first-generation immigrants preferred to access information through the ethnic media or other means that used their ethnic languages, whereas the younger generation born and/or raised in U.S. found the Internet to be a convenient source of information.

> *"Maybe it is a generation barrier. I will go online first. I hate calling because it's usually an automated message or you have to wait at least 29 minutes before you can actually speak to a person. I am just talking about the logistics of it. I am realistic about it."*
>
> *– Participant from Pacific Islander FG*

For adult immigrants who lacked computer literacy or the English language proficiency needed to access an English-language website, ethnic media were important source of information. The specific types of ethnic media preferred by participants differed somewhat across ethnic groups. For example, Koreans preferred newspaper sources because "newspapers last long" and they could "study the articles later." Pacific Islanders indicated that radio would be an effective means of information dissemination, because of its broad use in their community ("Radio will get more people") and its easy accessibility ("Radio is in the car, and radio is in the pocket"). Vietnamese reported the common use of TV, which is "on 24 hours." "Vietnamese weekly magazine" was also mentioned by a Vietnamese employee. Still, participants from all these communities indicated that all types of ethnic media would be useful sources of information.

When asked more specifically about which segments of the ethnic media coverage would be appropriate for the dissemination of information about the new health care law, participants in several FGs mentioned news; two participants, one Korean and one Vietnamese, mentioned that a special media segment or program covering the ACA would be helpful. A Pacific Islander employer indicated that even commercials would be helpful, although such an idea was disputed by a Hmong employee who stated, "the commercial is not filtered. As long as you pay for it you can get air time."

Getting assistance from their children or a younger generation was another common way to access information, expressed by many participants in the FGs.

> *"The younger generation is very savvy. Children can help parents. They can interpret for them, help them access the information."*
>
> *– Participant from Pacific Islander FG*

> *"I will ask my son to go to the website. We will both sit down and see what's in there and then decide."*
>
> *– Participant from South Asian Employee FG*

This view was shared by several participants in the younger generation who seemed to understand such a role expected of them. As a young South Asian employer who ran a family business with her mother succinctly put it, they were "the ones doing the calling for their parents" in their families. Such a practice seemed to be the case even for young people who had immigrated relatively recently, as suggested by two young Nepali owners who stated, "As soon as we came here, everything was on me" and "[It started] right after we got off the plane."

However, there were limitations to relying on young people who, after all, are not "experts," who "have their own busy lives," and who may not have the ability to adequately translate the information into their ethnic languages, as indicated by some participants.

> *"Helping means doing it for them. If you're working like 8am to 5pm and then you come home and spend 2-3 hours going over the form for them, that's hard for a lot of young working professionals. We don't even have the time for our own family sometimes. On weekend we might have time, but it's really hard even for our own immediate family."*
>
> *– Participant from Hmong Employee FG*

> *"Because the young ones may not have the proper language to communicate to the older …"*
>
> *– Participant from Pacific Islander FG*

The entities that can best assist them would need to have the "experience" and expertise, indicated by a participant from the Hmong employee focus group, and resources needed to provide accurate and

unbiased information in a way community members could understand. CBOs fit the bill, as they were touted as such entities in all the FGs, mostly without any prompt. The credibility of CBOs that effectively met the diverse needs of immigrants appeared to be firmly established:

"I would say community organizations because they are there to help you go through the process. It would be nice if you had a family member that's very knowledgeable like that. But if you don't, then outreach programs like that would be very good."

– Participant from Hmong Employee FG

"If there's an organization you can visit and get help that will be helpful. Like how they help you with applying for citizenship. A place where people can inquire, continually."

– Participant from Korean Employee FG

"We call for many reasons, from directions to which hospital we should go, and which lawyer we should hire or for any reason, we go to CBOs. We cannot afford internet and we are not computer illiterate."

– Participant from South Asian Employee FG

Specific assets CBOs might have were also keenly perceived by several FG participants.

"CBOs will be helpful because they have resources and they can guide you properly. They have computers. They have helpers. They've got interpreters so we can understand what's going on."

– Participant from South Asian Employee FG

CBOs were also perceived to be trustworthy, an important asset given the fear some community members harbored, as stated above.

"I need somebody that I can trust to say, 'this is what it means.'"

– Participant from Hmong Employer FG

"Someone you can trust. Someone who isn't there to milk you."

– Participant from Hmong Employee FG

"We trust community-based organizations so we go to them."

– Participant from South Asian Employee FG

Community health centers also were also considered to be trusted organizations where AA community members could get information related to health care. Community health centers were clearly preferred by low-income AAs who had used them.

"We come to see the doctor at _____, where they have workers who know how to speak our language. We know them, and they know us. So we [can] just come, pick up the paper, and then bring it home and spread it to neighbors, friends, and family and then can bring [the filled out forms] back here. They can also [post] the flyers at _____. When the patients come, they can get handed one. It is important and easy to get it here. If it is outside _____, I don't know if it is."

– Participant from Vietnamese Employee FG

Churches were also named as trusted institutions that could disseminate information. This is particularly the case in communities where many members are affiliated with Protestant churches such as the Korean and Pacific Islander communities.

"Churches provide health education sessions. A lot of people attend those sessions. It is important to get the information on insurance or Obamacare. We will go back and tell people about what we learned here. Educational opportunities like this will be helpful."
– Participant from Korean Employee FG

Korean Christian churches are known to be the bedrocks of Korean communities in the U.S., offering fellowship, business contacts, and social services (Kwon et al., 1997), with the vast majority of Korean immigrants attending church at least once a week (Kwon et al., 2001). Although less documented, Protestant churches seemed to play a similar role in Pacific Islander communities, perhaps to a greater degree, as the consensus among our Pacific Islander participants was that "everybody – over 90% of community members – goes to churches and that going to church is a family affair," involving the old and young.

As for the specific tasks community- or faith-based organizations can perform to provide information on the ACA implementation, "outreach" and "education," preferably conducted in ethnic languages, and translation of documents were mentioned:

"In-language outreach is needed." – Participant from Korean Employee FG

"Document translation is needed, and regular education and outreach (quarterly or biannually) through organizations like_____ is needed. Education and follow-up more than once on a regular basis, so that most people will get the information. If it's just one session, it's easy to miss."
– Participant from Korean Employee FG

"We need Korean language assistance. That's important. Not many Koreans speak English well."
– Participant from Korean Employee FG

Such outreach or education might need to involve publicizing the Covered California website itself, which appears to be an important task given that few participants knew about the website:

"There should be outreach about the website. People don't know about the website."
– Participant from Korean Employee FG

"If you know about the website, it would be a really big help. But if you don't [know] and you don't know nothing [about computers], then it [the website] will do nothing. Like me, I didn't know how [to use a computer]. Right now, I can't see very well. I don't know how to use [the computer] either."
– Participant from Vietnamese FG

Whoever is involved in outreach and education – be they younger family members, CBOs, or the media – it would be critical for them to be well-trained so that they could provide accurate information and adequate assistance, as indicated by participants in most FG s.

"There are volunteers at church who offer help but they are not experts. We need expert help."
– Participant from Korean Employee FG

"The media can get it wrong also. They need to be educated to give accurate information."
– Participant from Korean Employer FG

"Even the working professionals might need a lot of education and information about it."
– Participant from Hmong Employee FG

In terms of format of the information materials, "flyers like pamphlets" and a "booklet" containing information were also suggested by participants in several groups. Some Korean participants indicated that having the booklet inserted into the printed copies of ethnic Yellow Pages or placing it at Korean markets frequented by community members would be useful. The information thus provided would need to be clear, brief, and to the point:

> *"Booklets will be helpful, nothing too comprehensive or complicated, but something that includes key points."*
>
> *– Participant from Korean Employee FG*

An in-language hotline was also suggested by several participants:

> *"I would suggest a hotline, a language hotline … ACA hotline … there should be a person … If I need something on a computer I don't understand, I could pick up the phone and dial [the number] to ask, 'Please interpret this for me.' A hotline would be really good. A language hotline would be really good…they could set up a volunteer hotline for students."*
>
> *– Participant from Pacific Islander FG*

> *"If we have a hotline we can call." – Participant from South Asian Employer FG*

> *"A call center … You're supposed to be able to get a live-person if you need the language assistance."*
>
> *– Participant from Hmong Employee FG*

Accountants who could communicate to their client's tax implications of subsidized health insurance or providing insurance to employees could also be enlisted in disseminating information about the ACA to small business owners.

> *"I bet a lot of people here don't know about tax credits. Most people are not familiar to tax credit because they usually leave it to CPA."*
>
> *– Participant from Vietnamese Employer FG*
>
> *"If my CPA emails me, 'Hey _____, there's a new tax law,' I know that's important. I will look at it. But if it's not coming from him and then it's not really important as a business owner. Everybody works with a CPA. Most businesses do."*
>
> *– Participant from Hmong Employer FG*

Asked about whether they would pass along ACA- or other health care-related information to their employees, employers were divided. The consensus among Vietnamese employers was that they would definitely do so and further assist their employees in obtaining insurance, for example, by "allowing them to take time off" to get information and to sign up. A few Korean employers indicated that they also would. A Hmong employer, however, stated that health insurance is "the employee's private matter," which he would not feel comfortable getting involved.

Finally, as for the information to be provided in community outreach and education, several FG participants – for example, Korean, Hmong, and Pacific Islander employers – stated the need for clear communication of concrete information: "not too complicated' and "not too long." The information which FG participants wished to obtain included projected costs, most prominently "premiums" (e.g., a Korean employer); the amount of subsidies, which would determine whether the premiums were affordable (a Pacific Islander employer and a South Asian employer); the size of the workforce that would require the employer to provide insurance to their employees (South Asian and Korean employers); the penalties for not having insurance and not providing insurance to employees (Hmong employers); and

the definition of a family for determining their income eligibility for subsidized insurance and Medi-Cal coverage (Korean employers).

A few participants indicated that the information they needed went beyond basic technical information. It would need to help make a case for the ACA and to establish the legitimacy of the new health care system, as the new health care law is met with suspicion in some segments of the community, particularly among small business owners.

> *"There needs to be a clearer message that everyone is going to benefit from this plan. There is fear small business owners feel about its outcome."*
>
> *– Participant from Korean Employer FG*

SUMMARY

Differences between Small Businesses and Large Businesses

Compared to those working for large employers, Asian American small business owners and employees were more likely to have lower socioeconomic status, no health insurance coverage, and less health care options. These differences were not observed among Native Hawaiians and Pacific Islanders.

There were key differences between small business owners and employees and their counterparts at large businesses. Analysis of the California Health Interview Survey (CHIS) revealed that that Asian American (AA) small business owners and employees were more likely than those who worked for large employers to have lower socioeconomic status (SES) and less likely to be insured and access or use health care. Even among small business owners and employees, AAs who would be eligible for Medi-Cal were likely to be at an even greater disadvantage in these respects, not surprising given the low income threshold that determines the eligibility of Medi-Cal. In light of prior research findings that persons with lower socioeconomic status and without health insurance are more likely to suffer from poor health (Chittleborough et al., 2009; Yen and Syme, 1999), uninsured AAs who would be eligible for Medi-Cal constitute one of the highest risk groups for adverse health outcomes.

The associations between socio-demographics and employer type observed in AAs, which suggested lower socioeconomic status of small business owners or employers compared to those who worked for large employers, were not apparent in Native Hawaiians and Pacific Islanders (NHPIs). However, health insurance coverage and health care access were significantly associated with employer type for NHPIs as well, with NHPI small business owners and employees being less likely to be uninsured and to have regular providers than their counterparts who worked for large employers. Health care use (i.e., office-based doctor visit and ER visit) was not significantly associated with employer type for NHPIs.

Differences between AAs and NHPIs

Health insurance coverage and health care access widely varied among different ethnic groups, while AA and Pacific islanders experienced similar health care barriers.

Among AA small business owners and employees, uninsurance rates were higher for several ethnic groups — particularly Korean, South Asian, and Southeast Asian — than others. However, the circumstances under which AAs were uninsured were diverse across ethnic groups. For some groups, such as Southeast Asians and Koreans, high uninsurance rates largely reflected low private insurance rates, whereas for low-income South Asians who would be eligible for Medi-Cal, the high uninsurance rate may be due, at least in part, to their limited ability to take advantage of public insurance. Additionally, as we found in our multivariate analysis, members of the same ethnic group (e.g., Korean) may have differential access to health care, depending upon their nativity status. Given the extremely diverse socioeconomic conditions among AAs and circumstances under which they are uninsured, targeted strategies tailored to those circumstances, as well as the specific barriers each of the high-risk ethnic groups experience in accessing health care, might be needed to help increase their insurance coverage.

The small number of NHPIs included in the CHIS sample (N=165) and the associated low statistical power may have limited the ability to detect significant associations. As a result, there are fewer statistically significant data to report for NHPIs compared to AAs, let alone NHPI ethnic groups.

In the focus groups (FGs), there were few differences between AAs and Pacific Islanders. Instead, commonalities abounded between the two populations in barriers experienced in obtaining health insurance and accessing health care, and the hopes, confusion, and fears expressed regarding the ACA implementation, as well as the desire to learn more about it.

What set the two groups apart, however, was the mistrust of the system more strongly expressed by Pacific Islander participants. For one, Pacific Islander participants were mostly skeptical of Medi-Cal, being more keenly aware of the flaws in the way it is currently administered. They were also the ones who articulated "fear of the unknown" or any information that may be buried in the fine print that may come back and haunt them later. Similarly, some Pacific Islanders found less than adequate the services of community health centers, touted by Vietnamese employees. To a certain degree, such mistrust may be the result of the limited number of co-ethnic or racial providers from their communities who served them within the system. As indicated by some AA FG participants (e.g., Korean and Vietnamese), having co-ethnic providers who spoke their language, understood their culture, and could guide them through the health care system were critical in making health insurance and health care accessible and useful to them. This is an important lesson that may help fulfill the promises of the ACA for all populations.

Health Insurance Coverage

California's AA small business owners and employees had very high rates of uninsurance. Most small business owners felt that they could not afford to provide health insurance to their employees.

CHIS analysis revealed strikingly high uninsurance rates for California's AA small business owners and employees, ranging from 23% to 68% for those who would be eligible for Medi-Cal and from 10% to 51% for those eligible for subsidized insurance. These rates are far higher than the national average of AA uninsurance rates of 15% reported by the 2011 American Community Survey. Therefore, significant proportions of most AA ethnic groups are likely to benefit from Medi-Cal expansion and subsidized insurance under the Patient Protection and Affordable Care Act (ACA).

Our FG findings offer a glimpse of real-life circumstances that lead to high uninsurance rates for AA and NHPI small business owners and employees and also hint at the challenges ahead in expanding coverage for the uninsured among them. With some exceptions, owners in our FGs perceived high costs of insurance to be an insurmountable barrier to providing coverage for their employees. Employers themselves struggled to get themselves or their family members covered; with few exceptions in which they purchased insurance individually, most employers who were covered obtained coverage through their spouse's employer. A couple of employers (e.g., a Vietnamese nail salon owner) reported relying on a strategy of finding an additional job that provided insurance, while at the same time running their own business, to avoid paying high insurance premiums that come with individual plans.

To most of the employers in our FGs, providing insurance to their employees was simply beyond their financial capability. Most of them appeared relieved to learn that their workforce was small enough (i.e., less than 50) to allow them to avoid providing insurance to employees with no penalties. Furthermore, even if employers were willing to provide insurance, the burden of sharing costs was perceived to be too high in the eyes of some employees, who said they would rather buy food and pay for other necessities than paying for their shares of the premium. To the extent high insurance costs persist, ACA's success in expanding coverage for the uninsured is likely to be limited.

Health Status and Health Care

AA small business owners and employees with health insurance had significantly better health status than those without health insurance. Uninsured small business owners and employees resorted to alternative strategies, such as traveling to other countries or paying out-of-pocket, to get the health care services they needed.

Being insured was significantly and positively associated for AA small business owners and employees with self-rated health status and health care use, including office-based doctor visits and the use of preventive care such as flu shots, mammograms, and colorectal cancer screening. Our findings are in line with past research that has consistently demonstrated the substantial positive effects of health insurance coverage on the use of ambulatory and therapeutic care, preventive and diagnostic services, early detection of illnesses, and self-reported health status (Freeman et al., 2008; Hadley, 2003). Helping uninsured AAs to obtain health care coverage as promised by the ACA, therefore, may not only improve their health and well-being but also result in substantial cost savings to the U.S. health care system by reducing long-term costs preventable illnesses or untreated conditions may ultimately incur.

Throughout the FGs, those who were uninsured reported relying on various strategies to receive care. Koreans, for example, reported a practice in their community to visit Korea with a universal, single-payer system which they could get coverage and access health care after a stay of 3-months. India was another homeland where immigrants returned to seek medical attention. Some relied on the so-called "discount programs," designed to reduce costs associated with resource-intensive hospital care. Still others reported paying for doctor visits out of pocket and relying on ERs only when they had to, not knowing whether they would ever be able to pay the bills. The few participants who had individual insurance policies lamented high costs associated with them.

Having insurance and thus the peace of mind of being covered was mentioned as a high priority by many FG participants. While the administrative barriers to accessing Medi-Cal and the inconvenience of having to travel far to visit doctors (especially specialists) who saw Medi-Cal patients were pointed out as drawbacks of the system, comprehensive coverage and low costs were highly valued by low-income AAs. However, some participants perceived the low income threshold levels to qualify for Medi-Cal to be too low against the backdrop of the high cost of living in California, especially in large metropolitan areas such as Los Angeles, which would keep Medi-Cal out of reach for many low income AAs. Community health centers (or at least one such center mentioned by our Vietnamese employee participants) were immensely popular among low income AAs for low costs as they charged on a sliding fee scale using income levels and also, importantly, the clinic staff provided in-language assistance.

ACA Knowledge and Perceptions

Many small business owners and employees were not aware of specific details of key ACA provisions.

By and large, efforts to provide outreach and education about the coverage expansion under the ACA have not been successful. Few community members knew about the key provisions of the ACA that could critically impact them, and misinformation abounded. Across all FGs, small business owners and employees alike expressed strong desire to learn about the ACA and how it would impact them. Some FG participants, mostly employers, expressed concerns that health insurance premiums would rise under the ACA, that the ACA provision which mandates employers with 50 or more employees provide employee health insurance may lead to reductions in full-time jobs as some employers may choose to keep the workforce small enough to avoid providing insurance to employees. A couple of participants predicted that low-income people would choose to work and get paid less to keep themselves eligible for Medi-Cal. As the new health care law has been met with suspicion in some segments of the

community, particularly among small business owners, public education on the ACA may need to go beyond providing technical information; a strong case about the ACA may need to be made to establish the legitimacy of the new health care system to the AA small business community.

Sources of Information

While preferred sources of information about the ACA varied by generation, most AA small business owners and employees wanted to get information from trusted sources, such as ethnic media and community-based organizations.

For the most part, the currently promoted model of the Covered California website as a one-stop shop is unlikely to be culturally appropriate for many AA immigrants, as only those who were computer-savvy and who had sufficient access to computers – mostly the young, especially those who were born and/or raised in the U.S. – found such a website useful and convenient. The vast majority of immigrant communities, particularly the first-generation immigrants who came to the U.S. as adults, preferred and trusted other sources of information such as the ethnic media, younger family members, and, most importantly, community-based organizations (CBOs). In all of our FGs, CBOs or community health centers that cater to low-income residents were touted as trusted organizations with expertise and experience in providing vital, in-language services and eligibility assistance to immigrants. At the same time, it is critical to acquaint these persons or entities with accurate information about the ACA, as misinformation provided by some, such as the ethnic media, was also reported by our FG participants.

Providing in-language education and assistance, ideally by a trusted ethnic community organization or at least through an in-language ACA hotline, was perceived to be critical by both those who wished to get information to purchase their own insurance and who were eligible for public insurance. There was a critical need for co-ethnic members who spoke their languages and who could help navigate the complex public insurance system such as Medi-Cal to help the most disadvantaged members of AA communities to access health care. For those who had the means to purchase individual insurance, insurance agents in ethnic communities appeared to have been reliable sources of information, although to the extent that they do not point out the fine-print buried in the insurance policy that may be unpalatable to the potential client, they may not be perceived as trustworthy. Accountants who can effectively explain tax implications to their clients who owned small business could be also enlisted in disseminating essential information about the ACA to small business owners. Some owners were willing to pass along information on the ACA to their employees, while others expressed the desire to keep health insurance as the employee's private matter. A multi-pronged strategy will be needed to mobilize various key actors in the ethnic community to help the currently uninsured to access health insurance.

CONCLUSION

The Affordable Care Act provides a critical opportunity for individuals to improve their health status by gaining access to affordable health insurance coverage and necessary health care services. Our research indicates that AA and NHPI small business employers and employees have high rates of uninsurance and less access to health care services. While this community has much to gain from the ACA, they will still face significant barriers in getting insurance, including immigration status and language access. Unfortunately, many AA and NHPI small business owners and employees are still do not understand the ACA provisions that will help them provide insurance to employees or get insurance coverage for themselves and their families. As individuals, organizations, and other entities engage in outreach and education about the ACA to the AA and NHPI small business community, they must use resources trusted by the community to provide relevant information and help individuals enroll in coverage. By utilizing these targeted strategies, millions of AAs and NHPIs will finally be able get health insurance coverage and improve their overall health and well-being.

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APPENDIX

METHODS

Quantitative Research Component: CHIS Analysis

Data

We analyzed data from the nation's single largest state health survey, the California Health Interview Survey (CHIS). The survey is a critical source of detailed information on a broad range of topics including demographic and socioeconomic characteristics, health behaviors, health conditions and status, and access to and use of health care services among California's diverse population. CHIS is a random-digit-dial telephone survey of households that uses a multi-state stratified sampling design to represent California's non-institutionalized residents. Beginning in 2007, CHIS also includes a sample of cell phone-only households. Within each sampled household, one adult aged 18 years or older is randomly selected for an extended adult interview. The Adult File constructed from these interviews was used in our analysis.

Besides English and Spanish, CHIS is administered in four Asian languages: Cantonese, Mandarin, Korean, and Vietnamese. The administration of CHIS in Asian ethnic languages is a distinct strength of the survey in that most English-language surveys inevitably lead to the overrepresentation of those who are proficient in English and tend to have higher socioeconomic status (SES) than those who have limited English proficiency (Wong and Wang, 2008). Another strength of the survey was the oversampling of Vietnamese and Korean households to provide more reliable estimates of smaller ethnic groups. For more details on CHIS design and data collection, see http://healthpolicy.ucla.edu/chis/design/Pages/overview.aspx. To generate a large sample with sufficient statistical power, we pooled 2005-2009 CHIS data that include key information on health care access and use needed for this project.

Analysis

Analyses were conducted using STATA (version 11.0) and its survey estimation procedure to accommodate all design, ratio, non-response and post-stratification adjustments. First, we conducted univariate analyses to understand sample demographics. Second, we carried out a series of bivariate analyses to examine whether small business owners and employees were more disadvantaged than those who work for large employers in their socioeconomic status, health conditions and status, health insurance coverage, and health care use. We also conducted another series of bivariate analysis to investigate whether the two subgroups defined primarily by income levels that are likely to be intended targets of the Patient Protection and Affordable Care Act's (ACA) coverage expansion were likely to differ from each other and from those who earned higher incomes in the aforementioned socioeconomic, health, and health care dimensions. Targeted groups include those with incomes of up to 138% of the Federal Poverty Level (FPL) who will be eligible for Medicaid and those with incomes between 138% and 400% of the FPL who will be eligible for subsidized insurance. Additionally, in another series of bivariate analyses, we investigated whether insured Asian American (AA) small business owners and employees in these two subgroups were likely to have better health status than their uninsured counterparts. Lastly, we fitted a series of multiple logistic regression models to identify predictors of being uninsured for small business owners and employees, while controlling for other factors.

With the exception of univariate analyses to understand sample characteristics, all analyses were conducted using data weighted to reflect design characteristics of the survey, to account for oversampling of African Americans, Hispanics, and young adults. Weighted data were then adjusted for non-response and socio-demographic factors to be representative of the US civilian population on socioeconomic variables based on the 2000 Decennial Census.

Qualitative Research Component: Focus Groups & Key Informant Interviews

Selection of Communities for Focus Groups

Focus group (FG) recruitment targeted various disadvantaged ethnic groups with high rates of being uninsured throughout California. The selection of communities and their geographic location was guided by our analysis of 2009-2011 American Community Survey data. Specific ethnic communities and counties thus identified are the following: Southeast Asians such as the Hmong and Cambodians in Fresno County; the Vietnamese in Santa Clara County; Tongans in Sacramento County; and Koreans, Pakistanis, and Bangladeshis in Los Angeles County.

Participant Recruitment

Leveraging APIAHF's extensive network of community-based organizations (CBOs), we collaborated with CBOs working in these communities to recruit and organize FG s. We developed a FG guide for the participating CBOs in which we laid out the participant recruitment protocol; the responsibilities of the recruitment coordinator and the interpreter (where needed); and the recruitment criteria such as owning or working for small businesses with fewer than 50 employers, identifying oneself as the specified ethnicity, and living in the specified county, This guide was shared with our community partners and used in one-on-one training sessions we conducted with community coordinators, mostly by phone, to guide their recruitment efforts. Since employers and employees are likely to have different views when it comes to health care coverage provided by the employer, we planned to assign them to separate groups.

While most of our community partners were able to help us recruit FG members who fit the profiles we specified, we allowed flexibility where community conditions called for it. For example, we set out to recruit Pakistanis and Bangladeshis in Los Angeles County. However, Pakistanis business owners were difficult to recruit. In the end we conducted FGs composed of multiple South Asian ethnic groups, which included Nepali business owners. We also initially planned for a FG in the Sacramento County to only include Tongan employers, the group in the end included both employees and employers of Pacific Islanders (PIs) of other ethnicities, such as Samoans and Fijians. Similarly, we also included participants of neighboring counties to participate when they showed up unexpectedly at the FG. The accommodations were impromptu, but their contributions to the rich discussion provided by wider and more diverse perspectives more than justified their inclusion. Information on the specific ethnicity and insurance status of the FG participants is provided in Table 9. All FG participants were compensated for their time with a gift card. The value of the gift card was determined by each of our community coordinators.

How Focus Groups were Conducted

FGs were conducted in the participants' primary -language. There were three FGs conducted in English, two conducted by a Korean facilitator, and the others were conducted with the assistance of interpreters. Prior to the FGs, a brief pre- FG survey was administered to all the participants to ask about their ethnicity, health insurance status, the type of insurance they had, whether the employer provided insurance, and the types of persons/organizations they trusted most to provide information about health insurance coverage.

Focus Group Data Entry & Analysis

All the FGs were digitally recorded and transcribed. The transcripts were analyzed using ATLAS.ti, a qualitative data management software. The software was designed for coding and analyzing qualitative texts and allows researchers to cross-reference, index, search, and retrieve data through a keyword coding process (Muhr, 2004). We established a series of preliminary codes to include both category codes to identify respondents' demographic characteristics as well as descriptive and thematic codes identified from the literature and generated from transcript review reflecting emergent themes. New descriptive and thematic codes were added as new ideas and themes emerged after each subsequent transcript. Qualitative data analysis was based on a constant comparative approach and was ongoing throughout and consequent to the FG data collection processes (Miles and Huberman, 1994). The analysis included coding of qualitative data including FG notes and transcripts and other interview field notes. The data analysis also entailed content and interpretive analysis including descriptive and thematic coding and developing key analytical domains and constructs based on the coding analysis. Frequent "member checks" were conducted during this process to discuss clarify and validate the qualitative findings (Lincoln and Guba, 1985).

Key Informant Interviews

In-depth interviews were conducted with six key informants who served the target communities in various capacities. One of them was conducted by phone, and the rest in-person. The purpose of key informant interviews was to gather a broad range of information about the barriers low-income AAs and NHPIs experience in accessing health care. Two of them were CBO employees who assisted newly-immigrated low-income AA residents such as refugees. Two key informants worked for county health departments. Two worked for organizations that provided health plans for Medi-Cal recipients and advocated better services for them. Results of these interviews informed the development of FG questions used mostly in groups composed of small business employees, as well as helping to interpret FG findings in the contexts of low income communities and the delivery of publicly financed health care (such as Medi-Cal) for them.

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