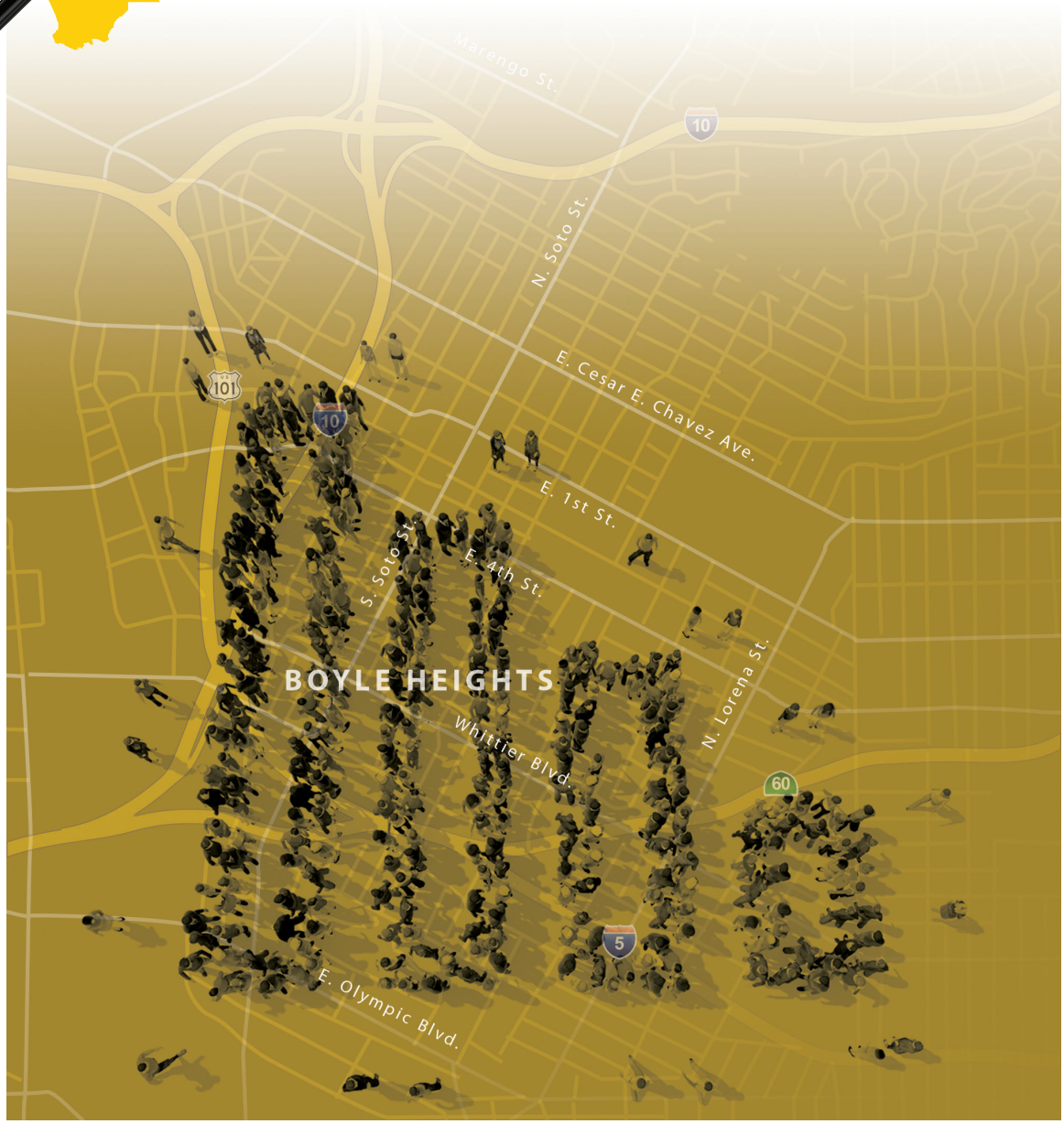
A RESEARCH SERIES OF THE PAT BROWN INSTITUTE AT CAL STATE LA

IN FOCUS: BOYLE HEIGHTS



Geography Matters:

A Comparative Analysis of the Uninsured Population of the United States, Los Angeles, and Boyle Heights

ALI MODARRES PHD

CAL STATE LA
PAT BROWN INSTITUTE FOR PUBLIC AFFAIRS
Unleashing the Power of Participation

Building Healthy Communities
Boyle Heights

IN FOCUS

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City Heights
Del Norte County Adjacent Tribal Lands
Eastern Coachella Valley
East Oakland
East Salinas (Alisal)
Long Beach
Richmond
Sacramento
South Los Angeles
South Kern
Southwest Merced/East Merced County



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A Comparative Analysis of the Uninsured Population of the United States, Los Angeles, and Boyle Heights

Ali Modarres PhD
Director of Urban Studies
University of Washington Tacoma

Goals and Objectives of This Report

- This report provides an in-depth demographic analysis of health insurance coverage at various scales: national, Los Angeles County, and the Boyle Heights community, in order to highlight the importance of small area analysis in advancing effective healthcare policies. This information is used to identify some of the ways Boyle Heights differs from the rest of the region and how its demographic characteristics may require particular attention to age, employment dynamics, and educational attainment. By analyzing the current patterns of coverage (including no coverage), differences in access to the insurance market will be made clear. Using current patterns and projected demographic changes, the report concludes by assessing what health insurance coverage may look like over the next five to ten years.

Key Recommendations

- Healthcare policy will do better by focusing and fine tuning its approach, using small area analyses.
- Policies aimed at access to health insurance and healthcare services should focus not just on current trends but also on changing demographics and economic and social restructuring.
- Aging and neighborhood demographic shifts cannot be fully incorporated into larger policy narratives. Community advocacy and a focus on smaller geographies is needed to adjust and/or change policies that prove less effective in particular neighborhoods.

INTRODUCTION

Based on the annual American Community Survey (ACS), the estimated number of uninsured Americans declined from 45 to 27 million between 2013 and 2016, with the largest drop occurring between 2013 and 2014 (8.5 million). During the same time, the population of the United States increased by an estimated seven million, to 318 million, suggesting that the drop in the uninsured population is in fact significant (i.e., it is declining even though population is increasing). By the census of 2015, the uninsured population had dropped by another seven million. According to the latest ACS (2016), the number of uninsured reduced by another 2.4 million between 2015 and 2016. At this rate, without policy intervention, the rate of the uninsured population could stabilize in a few years. In light of recent attempts to modify or eliminate the Affordable Care Act (ACA), we need to consider the consequences of such a reversal. In particular, we must try to understand the demographic and geographic particularities of their potential/differential impact on communities. For that reason, in this report, I will provide an in-depth demographic analysis of health insurance coverage at various scales: national, Los Angeles County, and the Boyle Heights community in Los Angeles, in order to highlight the importance of small area analysis in advancing effective healthcare policies. Census and other data sources are used to identify some of the ways Boyle Heights is unique in its demographic characteristics and why it is important to pay particular attention to age, employment dynamics, and educational attainment at the community level to understand the uneven impact of changes in healthcare policies. By analyzing the current patterns of insurance coverage (including no coverage), differences in access to the insurance market will be made clear. Using current patterns and projected demographic changes, the report concludes by assessing what health insurance coverage may look like over the next five to ten years.

Uninsured Population

In this section, a brief overview of the national, Los Angeles County and Boyle Heights patterns will be discussed. These descriptions provide the much needed context for who (which demographic group) has benefited from the recent changes and how this varies with different geographic scales.

Nation

The reduction in the uninsured population from 2013 to 2016, while good news, begs an important question. Who has benefited the most? This question assumes that as with other public goods, this positive outcome is distributed in an uneven manner.

The largest group of uninsured is, unfortunately, the working age population (18-64). Of the nearly 19 million reduction in the uninsured population, 15 million are in this age group (see Figure 1). As indicated above, the decline in unemployment rates, leading to the availability of insurance through employers, and perhaps the impact of ACA, have resulted in the most promising and positive impact on our population.

Ironically, even though the rate of decline in the uninsured population has remained consistent for African Americans (at about 14% of the total uninsured population in any one year from 2013 to 2016), it has dropped less than 1% for Asian Americans, declined by 3% for the Non-Hispanic White population and has increased by 33.4% to 37.4% for the Latino population (more than one in three). Note that, for the latter, it is not the actual number of Latinos, but the percentage of uninsured who are Latinos. This pattern holds for both the native and foreign-born population, where the former has witnessed a decline of around 3% in their uninsured rate and the latter has absorbed a 3% increase. The largest percentage increase in the uninsured population for the foreign born population is among those who have not naturalized. This is to be expected, since they may have benefited less from employment and changes in access to the insurance market.

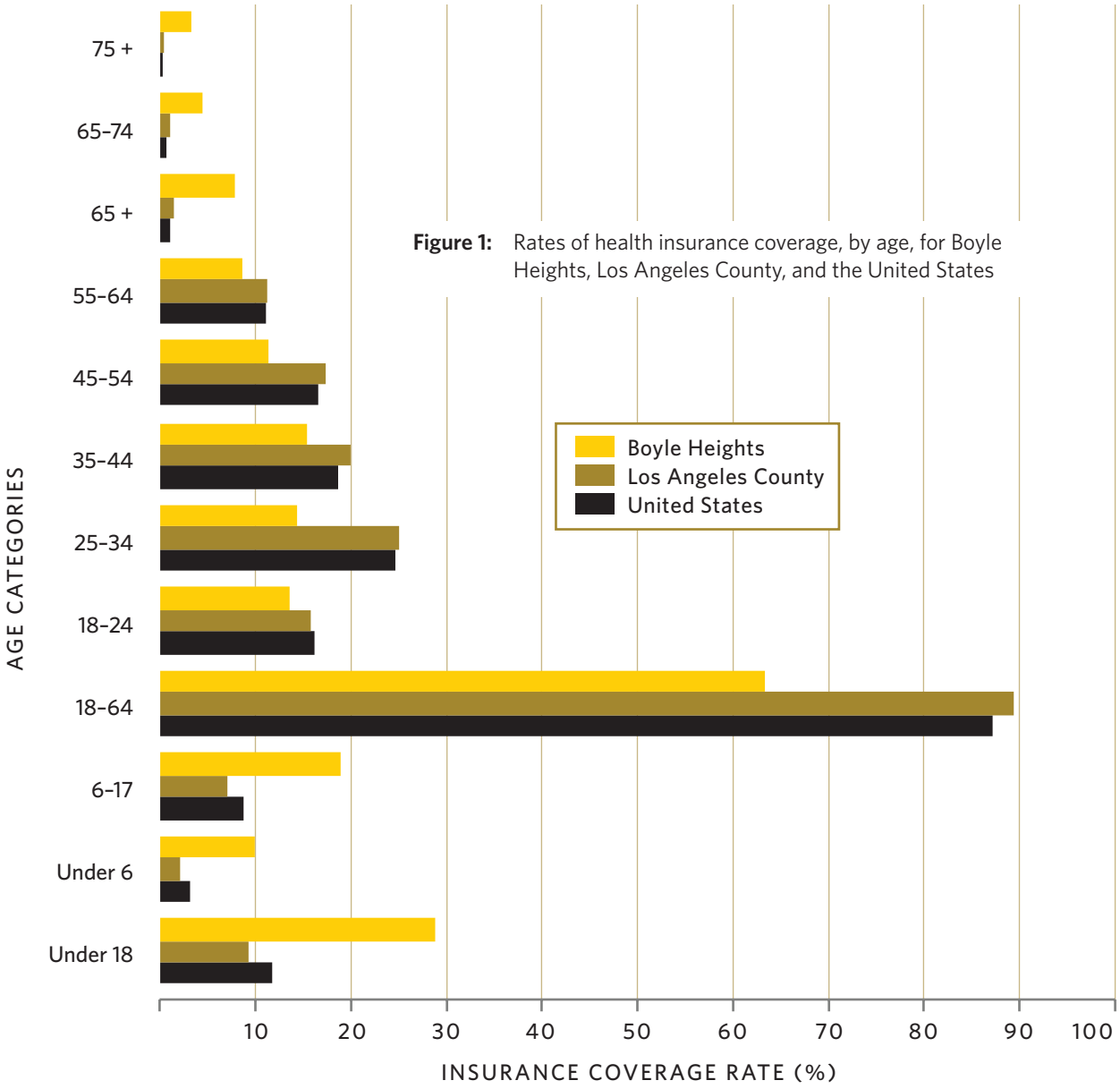


Figure 1: Rates of health insurance coverage, by age, for Boyle Heights, Los Angeles County, and the United States

An obvious, but important, factor is also educational attainment. Between 2013 and 2014, those with some college education witnessed a drop of about 3% and those with a bachelor degree or better saw slightly over a 1% reduction in their share of the uninsured population. This differential can be explained by the fact that those with higher education were impacted less by the downturn in the economy last decade and continued to be employed. Those with less education potential had more to benefit from the recent economic gains and the drop in unemployment rates.

Employment in particular industries does not seem to affect the observed changes, except for construction, which has seen a growing share of the uninsured (this may simply mean that employees in other industries have received access to health insurance at a faster rate). Sales and office occupations, on the other hand, seem to have reduced their share of the uninsured population.

Los Angeles County

National patterns are somewhat repeated in Los Angeles County. However, there are important differences.

From 2013 to 2014, the estimate for the uninsured population was cut nearly by half, from slightly over 2 million to below one million. Unlike the nation, there is no dramatic difference among various age cohorts. The level of decline seems to be more or less equal, except for a few groups. The share for the 18-24 age group dropped by nearly 3%, while the 25-64 group witnessed an increase in their share.

The share of Latinos among the uninsured increased by nearly 5%, while other groups witnessed a decline in their share. Similar to national patterns, the native born population had a smaller share of the uninsured in 2016, compared to 2013. However, for the foreign born population, the share increased by nearly 5%. Within this group, the naturalized population did actually improve its status by having a smaller share in 2016. This means that those who were not citizens witnessed an increase in their share by nearly 9%. Once again, it is important to remember that given the large reduction in the number of uninsured, changes in the share of a particular population cohort does not mean that more people were now uninsured. It simply means that some groups are experiencing unequal access to the insurance market and therefore are becoming a more significant portion of the uninsured population.

Influence of educational attainment is similar to the national pattern, with the less educated representing a larger share of the uninsured population and those with more advanced degrees benefiting from higher rates of employment, and most likely, employer-provided benefits. However, something ironic appears in the Los Angeles County that requires an explanation. Compared to 2013, in 2016, the employed population had a larger share of the uninsured population than the unemployed! This is not a function of working full-time or part-time. In fact, full-time workers saw their share of uninsured increase from 2013 to 2016. Numerically, this means that while the overall number of uninsured has declined precipitously, the rate of decline has been faster for those who do not work or work part-time. A partial explanation for this pattern is earnings and occupation. As in the case of national patterns, occupations in construction, natural resources, and maintenance witnessed their share of the uninsured increase. However, those with personal "earnings" between $15,000 and $49,999, regardless of their occupation, are falling behind in the reduction of their uninsured cohorts. Perhaps, in the case of Los Angeles County, at this level of income, insurance becomes a difficult service to attain, while paying for all other expenses in a relatively costly region. An alternative, and potentially interesting, answer could be that between economic recovery, higher employment rates, and ACA, the lower income population has gained a much higher access to the insurance market, and those incomes above poverty, but below middle income categories, are growing to become a larger population among the uninsured. Once again, it is the not total number, but the share of the uninsured that is being considered here.

Boyle Heights

As this report was being written, the 2016 ACS data was not available at the ZIP Code level. As such, an analysis similar to the one above cannot be conducted for Boyle Heights. However, in what follows (a comparison of National, Los Angeles County and Boyle Heights data for 2015), Boyle Heights patterns for the uninsured population will become clear.

Comparative Analysis

Using the ACS 2015 dataset at individual and ZIP code levels, this section provides a deeper and comparative analysis of the uninsured population at national and local levels. By examining various demographic cohorts, data for Boyle Heights (which is an aggregation for ZIP Codes 90023, 90033, and 90063) is compared with that for Los Angeles County and the nation.

According to the ACS 2015, the estimated civilian population of the U.S. stood at 311.5 million. Among this population, 13% or 40.5 million, were reported as uninsured. The same data for Los Angeles County estimated the uninsured population to reach 18.4% of the nearly 10 million residents. For Boyle Heights, the uninsured made up 29.4% of the total civilian population. The significant difference between these three geographies suggests that varying socio-demographic dynamics need to be fully understood in order to fully comprehend the impact of national policies on specific communities and/or regions. Below is an attempt to produce such a comparative lens on access to health insurance.

Age

Figure 1 provides a comparative analysis for various age cohorts by the selected geographies. Please note that the three larger/aggregate cohorts (Under 18, 18-64, and 65 and older) are included in this graph, along with some of the subcategories within these age cohorts.

The working age population makes up the largest proportion of the uninsured in all three geographies. However, Boyle Height's proportions are smaller in this age cohort. Unlike the nation or Los Angeles County, Boyle Heights has a much larger proportion of its population under 18 in the uninsured category. This is true both for those under 6 and 6 to 17 years old. This could be a function of parents' employment status and types and their access to particular forms of health coverage.

The proportion of the uninsured elderly is much higher in Boyle Heights than the other geographies. This is particularly alarming, since the two reports from the Congressional Budget Office on suggested proposed changes to ACA (from May and June) could increase the number of uninsured population for those 50-64.[3] In other words, as the older population faces a challenge for access to health insurance coverage, we need to be mindful of how any changes in policy could translate negatively on those who are just about to leave employment or have already passed their employment age. Given the uneven distribution of population by age, the impact in some geographies could be more severe than in others. These are typically older neighborhoods and regions where younger people leave to seek opportunities elsewhere.

Putting the entire picture together, residents of Boyle Heights are facing a particular challenge. Both the younger and older residents seem to have a more limited access to the insurance market, compared to L.A. County and the nation. While one can imagine higher levels of access to health insurance through certain employment related policies (e.g., universal healthcare policies that assure a higher access to insurance among the youth, which ACA attempts to do), the elderly population requires more attention. As a graying nation, whose median age is increasing gradually, this could potentially become a significant national and local health policy challenge within the next couple of decades. We have to remember that boomers are beginning to retire and we have not had a national dialogue around what it means to be a "grayer" nation, region, or community.

Educational Attainment

One of the first indicators of socioeconomic and employment status is educational attainment. Figure 2 clearly illustrates that slightly less than two-thirds of the uninsured population in Boyle Heights have not graduated from high school. Those with high school education, some college, a bachelor's degree or higher constitute a much smaller proportion of the uninsured, not only at all three geographic levels, but more pronouncedly in Boyle Heights. This clearly indicates the importance of multiple policies, and their simultaneous consideration, in improving overall quality of life. Access to quality education, backed by better policies on employment (e.g., family benefits), could significantly improve our collective health environment and create more equitable conditions.

[3] June 26th and May 24th reports.

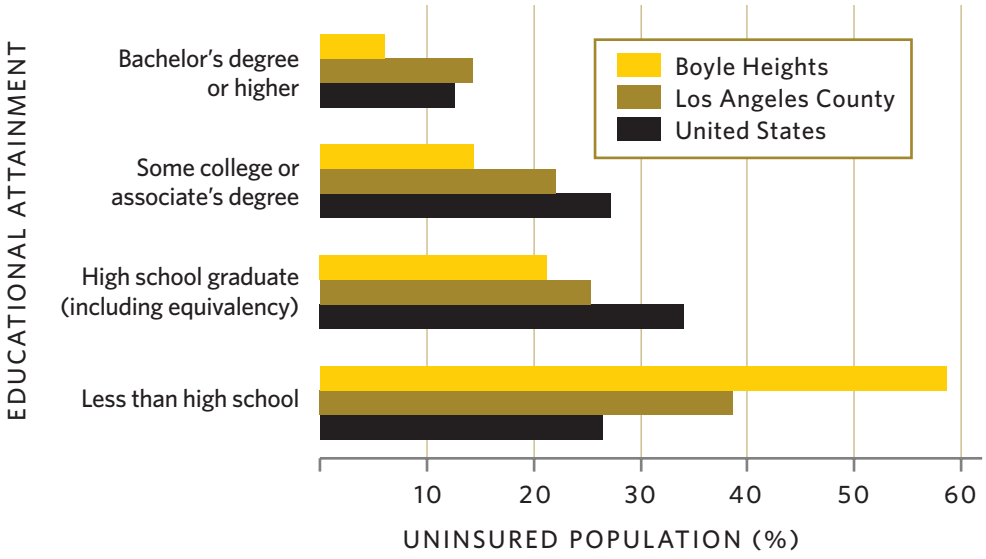


Figure 2: Proportion of the population that lacks health insurance, by educational attainment, for Boyle Heights, Los Angeles County and the United States

Employment Industry and Occupation

The impact of educational attainment directly manifests itself in employment industry patterns. As Figure 3 illustrates, the largest proportion of the uninsured, at national and L.A. County levels, are in service industries, particularly arts, entertainment, recreation, accommodation and food services. For Boyle Heights, however, the largest category is manufacturing and retail. This is also confirmed in occupation categories, where production, transportation, and material moving occupations have the second largest category of uninsured population in Boyle Heights, after sales and office occupations. While having a sizable uninsured population among those employed in food industry and retail might be expected, the large presence of the uninsured among those employed in manufacturing in Boyle Heights requires further research. However, one probable cause is the scale of manufacturing, which could include a number of smaller production facilities.

Earnings

One of the more interesting aspects of public policies is their unintended consequences. One of these is the phenomenon of benefit cliffs. These typically affect cohorts of the population which, due to their particular socioeconomic status, can benefit neither from market-based nor publically provided services. This appears to be true in healthy coverage patterns. Figure 5 reflects earning patterns for all three geographies. Those earning between $5000 and $25,000 are overrepresented among the uninsured population. In Boyle Heights, 58% of the uninsured fall in these income categories. At the national and Los Angeles County levels, these figures are 53.4% and 57.6%, respectively. Similarities among all three geographies suggests that certain income levels need to be targeted more rigorously for access to health insurance coverage, since they are falling off the benefit cliff between the very low-income and those earning more. The difference between those in the $15,000-$24,999 category and those in the $25,000-$34,999 is striking (see Figure 5).

Types of Insurance

An important step in understanding patterns of access to the health insurance market is analyzing the types of insurance used by various population cohorts. To perform this analysis at all three geographies, a database of Great Data (*www.GreatData.com*) was used. Similar to ACS, this data also provides 2015 information at ZIP code level. Since the only demo-

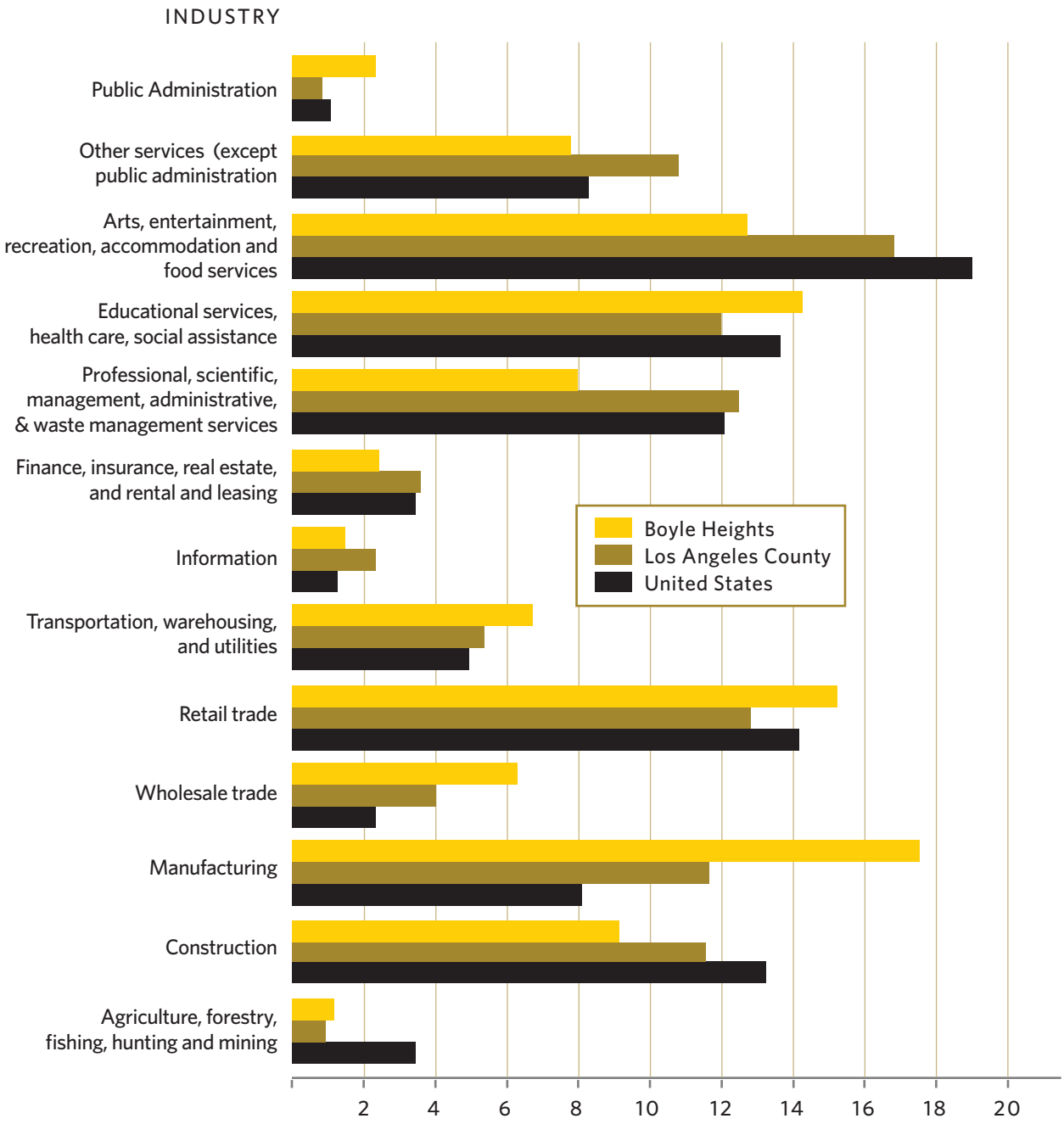


Figure 3: Proportion of the uninsured population, by industry, for Boyle Heights, Los Angeles County and the United States

graphic indicator in this database is selected age cohorts, in this section, the analysis is limited to only this factor.

Figure 6 provides an overview of types of insurance for all three geographic scales, at the aggregate level. Based on previous analysis of employment patterns, education, and income, the limited access to health insurance through employer-based insurance for Boyle Heights residents is not surprising. As illustrated, the employer-based health insurance in Boyle Heights is half the national level and 17 percentage points below L.A. County. Reliance on Medicaid, however, is a significantly larger factor in Boyle Heights than the other two geographic levels. About one-third of the population relies on this public

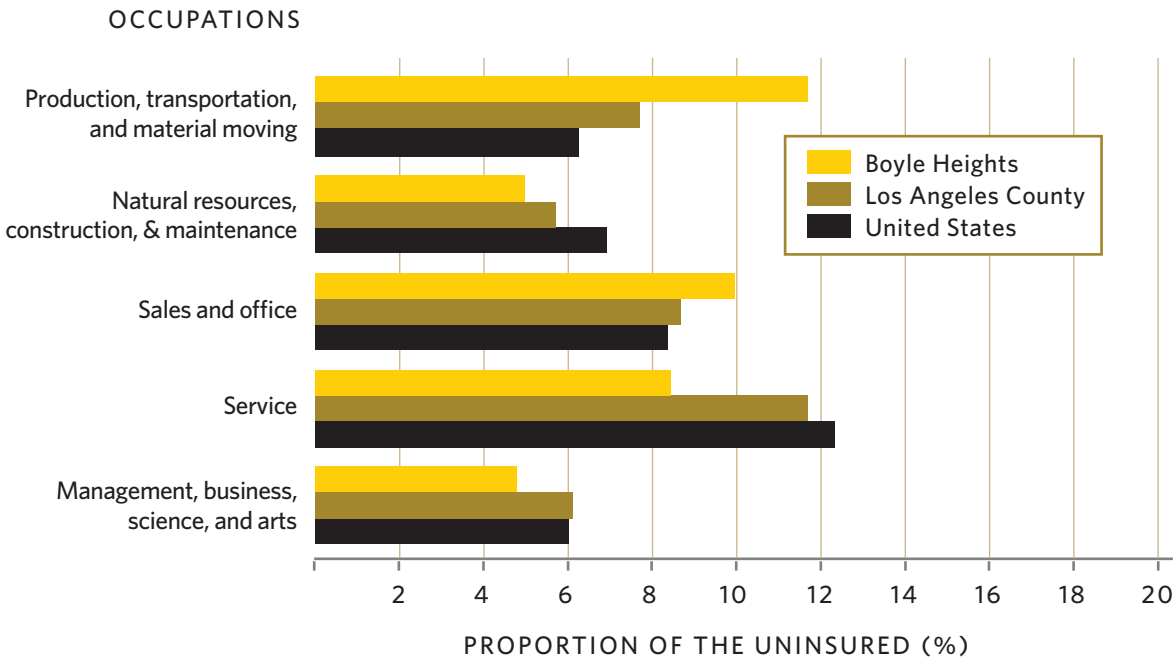


Figure 4: Proportion of the uninsured population, by occupation, for Boyle Heights, Los Angeles County and the United States

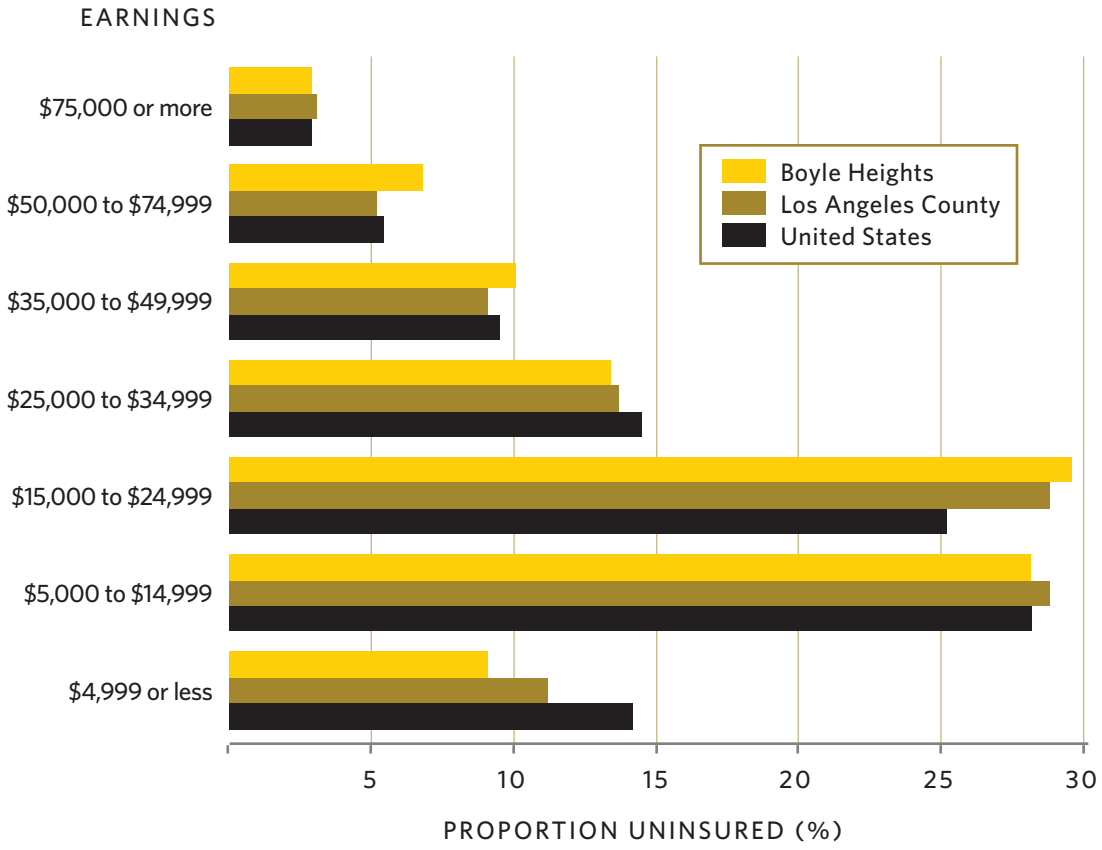


Figure 5: Proportion of the uninsured population, by earnings, for Boyle Heights, Los Angeles County and the United States

insurance. Given the analysis in the previous section, it should not come as a surprise that the uninsured population is a significantly larger proportion in Boyle Heights than the other larger geographies.

Among the population under 18, reliance on Medicaid is large in Boyle Heights. As Figure 7 illustrates, nearly two-thirds of this age cohort relies on this type of publicly provided health insurance. At the national and L.A. County levels, the figures are smaller, but still significant (43% in L.A. County and 34% at the national level). Conversely, employer-based insurance is accessed by 46.6% of the population below 18 at the national level and 38.6% in L.A. County. In a stark contrast, only 16.7% of this population cohort in Boyle Heights has access to employer-based insurance, which could be directly connected to the employment status and occupation of their parents. This is partially revealed in Figure 8, where an overview of access to insurance for the 18-34 population can be observed. Given that 43.5% of this age cohort (nearly twice the national level) has no health insurance coverage provides a clue to why such a large portion of the population under 18 in Boyle Heights has to rely on publicly provided health insurance coverage. This is a disturbing pattern, since it might suggest that while young families seek health care services for their children (using publicly available resources), they do not rely on such services for themselves. The difference between the nation and Boyle Heights in access to employer-based insurance is striking. Slightly over half of the 18-34 population has access to this type of insurance at the national level, whereas in Boyle Heights it is 26.8%. This figure is also smaller than the 42. 8% in L.A. County.

This pattern is repeated for the 35-64 population (see Figure 9), where a large portion has no health coverage and employer-based insurance benefits less than a third of the population. Overall, it appears that the working age population (as discussed earlier) has limited access to market-based insurance coverage through employment. While they do work, they seem to receive limited (or no) health benefits through their employers. As such, they either live without insurance, or when absolutely necessary, rely on Medicaid. A combination of education for policymakers and progressive employment policies is needed to shore up positive changes in local and national policies for improved access to health insurance.

For the older population, Medicaid and Medicare are major sources of health insurance coverage (see Figure 10). While this is generally expected, it is obvious that the older residents of Boyle Heights need to rely more on a combination of both insurance types than their L.A. County and national counterparts. They also have a more limited reliance on the combination of employer-based and Medicare insurance. This could be a continuation of what they have experienced during their working years, when their access to employer-based insurance was limited.

Using the same data, four maps (Figure 11 through 15) were prepared to examine the geographic distribution of the uninsured population by age cohorts in Los Angeles County. All of these maps illustrate the relationship between the socioeconomic status of a community and its pattern of access to health insurance. The low-income communities in Central L.A. County, San Gabriel and San Fernando Valleys, and communities to the north stand out as geographies with limited access to health insurance. The blue lines on this map identify the boundaries of the three selected ZIP codes that overlap Boyle Heights. As illustrated, this community (among a few others in the region) contains a concentration of the population under 18 with no coverage. The pattern is more severe for the 18-34 population. In fact, a large portion of South L.A., Boyle Heights, East L.A., and Westlake Pico Union are identified as a major concentration of no coverage for this population cohort. Orange and Ventura Counties are included on these maps, and selected communities of lower income and larger Latino populations, such as in Santa Ana and Oxnard, appear on these maps as having limited access to insurance for this population cohort, as well. For the 35-64 age cohort, a similar pattern can be

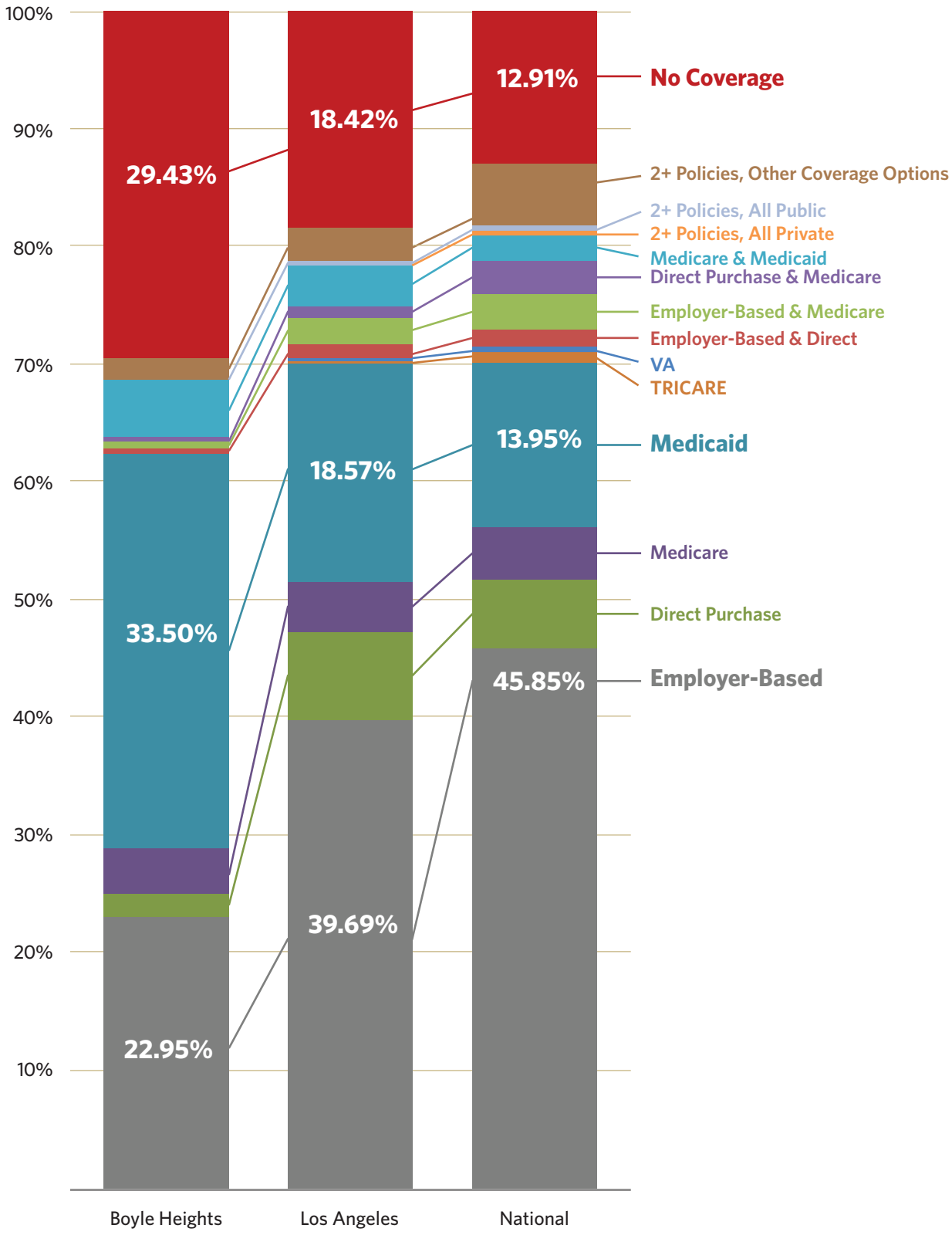


Figure 6: Percent population by type of health insurance, for the aggregate population, in Boyle Heights, Los Angeles County, and the United States, 2015

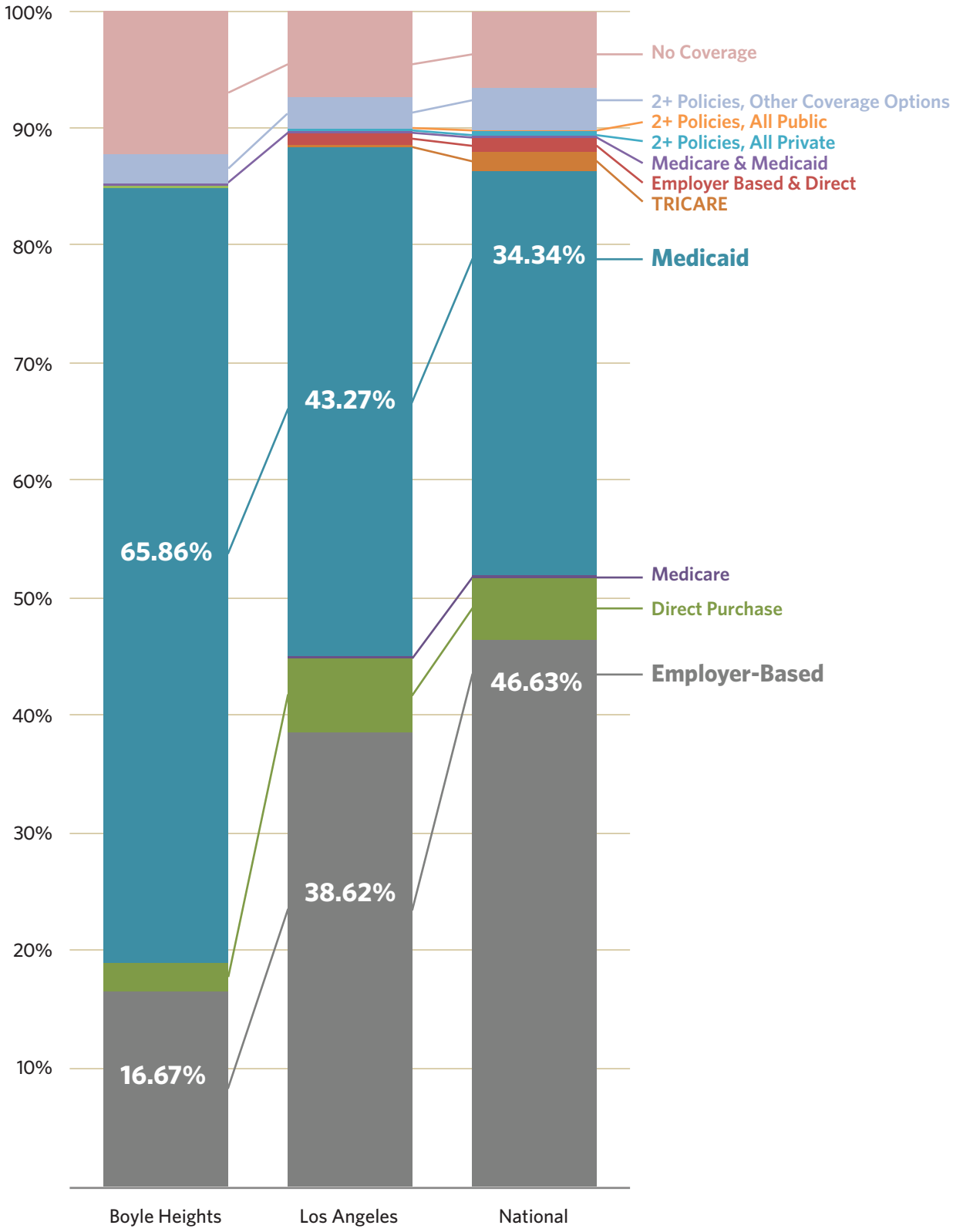


Figure 7: Percent population under age 18, by type of health insurance, in Boyle Heights, Los Angeles County, and the United States, 2015

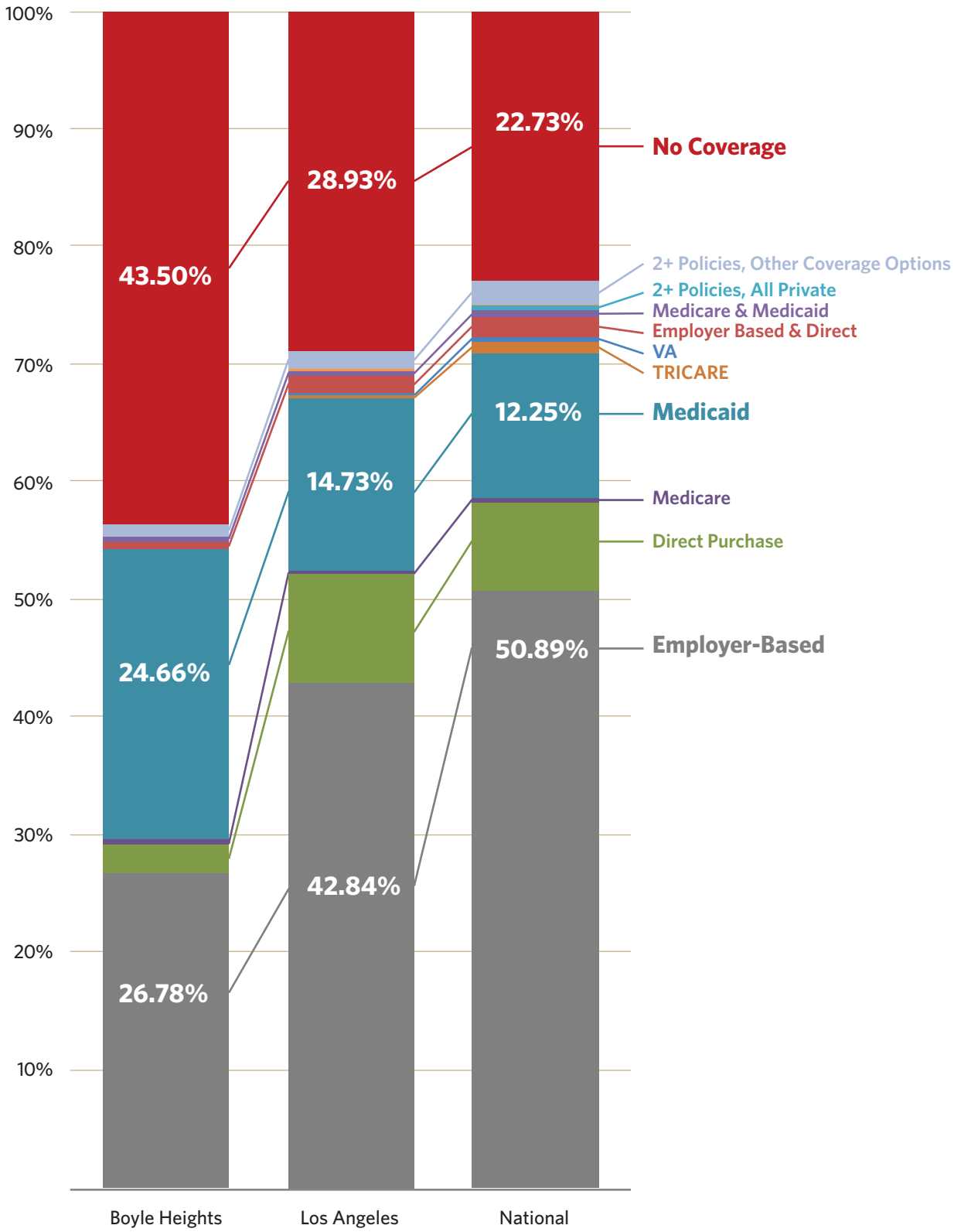


Figure 8: Percent population age 18–34, by type of health insurance, in Boyle Heights, Los Angeles County, and the United States, 2015

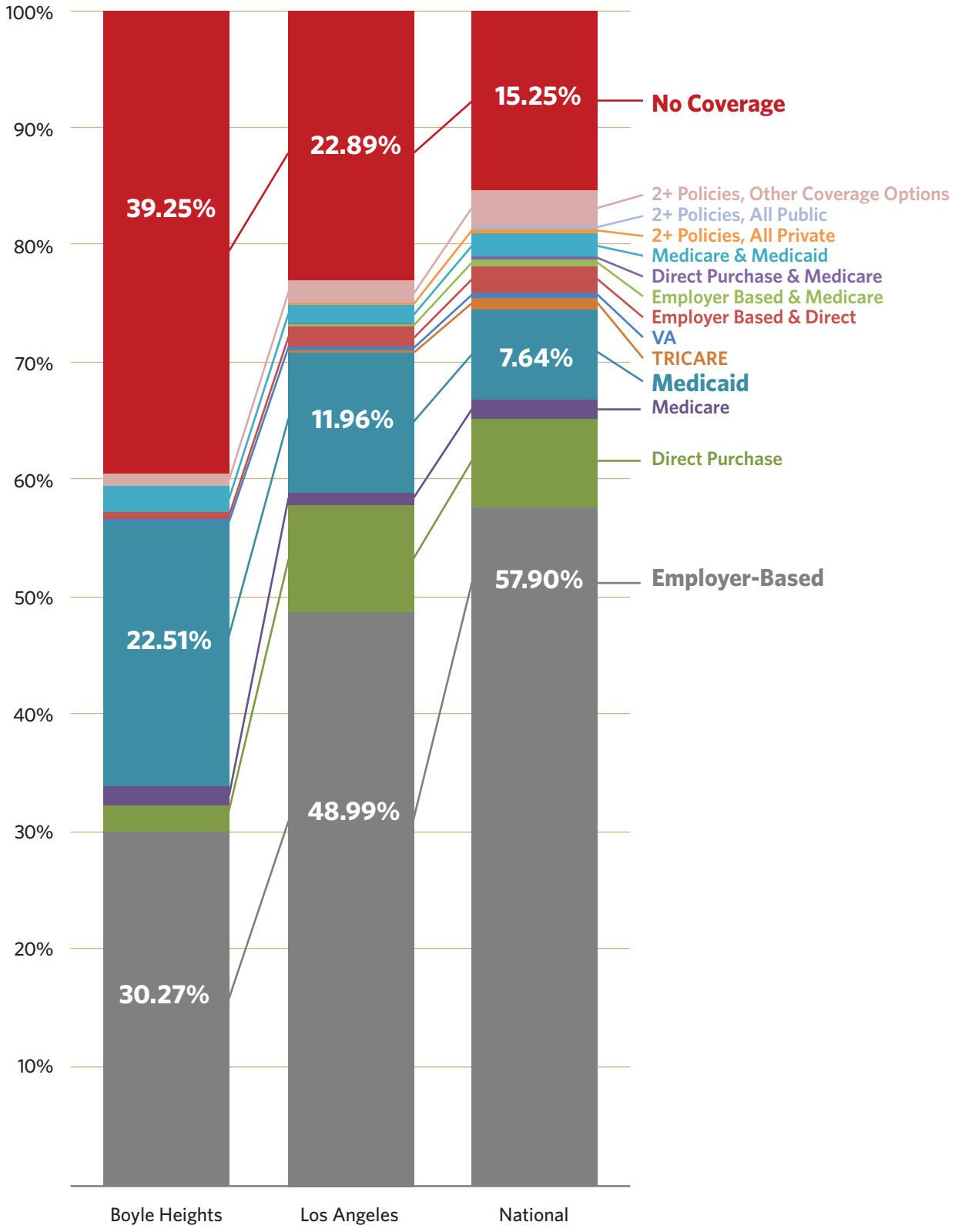


Figure 9: Percent population age 35–64, by type of health insurance, in Boyle Heights, Los Angeles County, and the United States, 2015

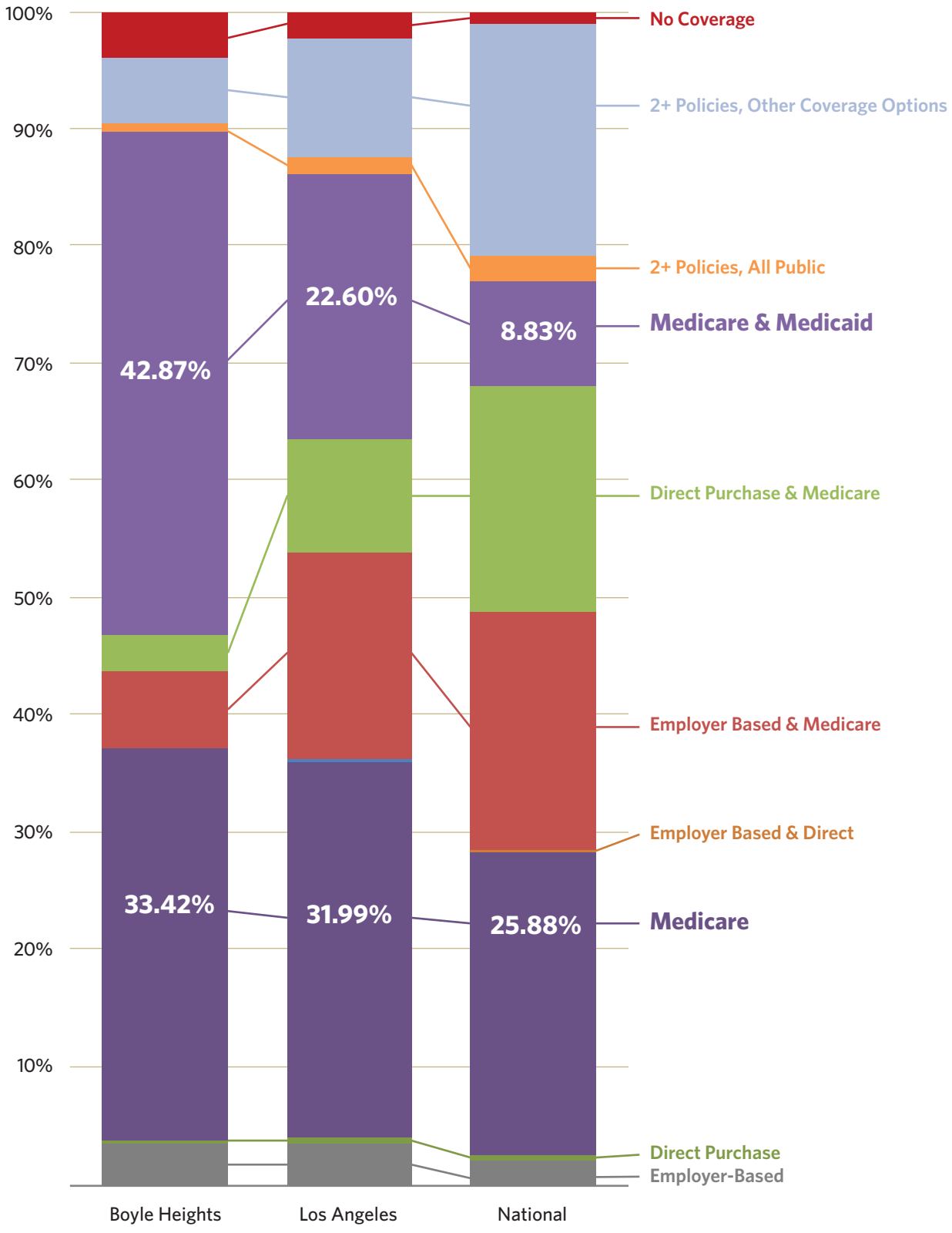


Figure 10: Percent population age 65 and over, by type of health insurance, in Boyle Heights, Los Angeles County, and the United States, 2015

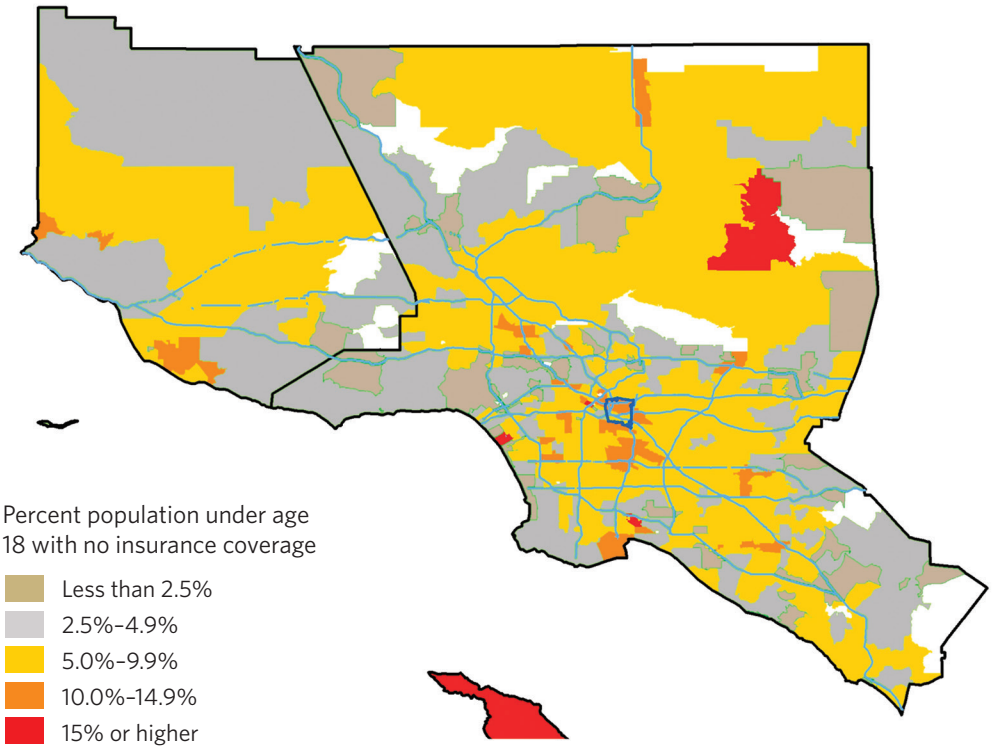


Figure 11: Percent population under age 18 with no insurance coverage

- Less than 2.5%
- 2.5%–4.9%
- 5.0%–9.9%
- 10.0%–14.9%
- 15% or higher

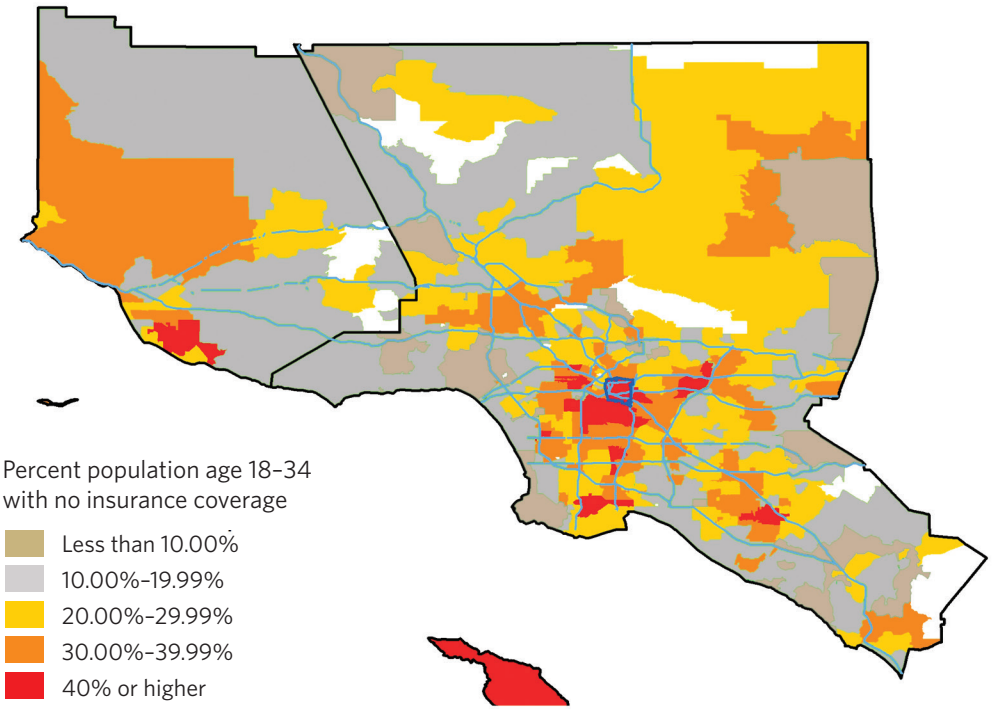


Figure 12: Percent population age 18–34 with no insurance coverage

- Less than 10.00%
- 10.00%–19.99%
- 20.00%–29.99%
- 30.00%–39.99%
- 40% or higher

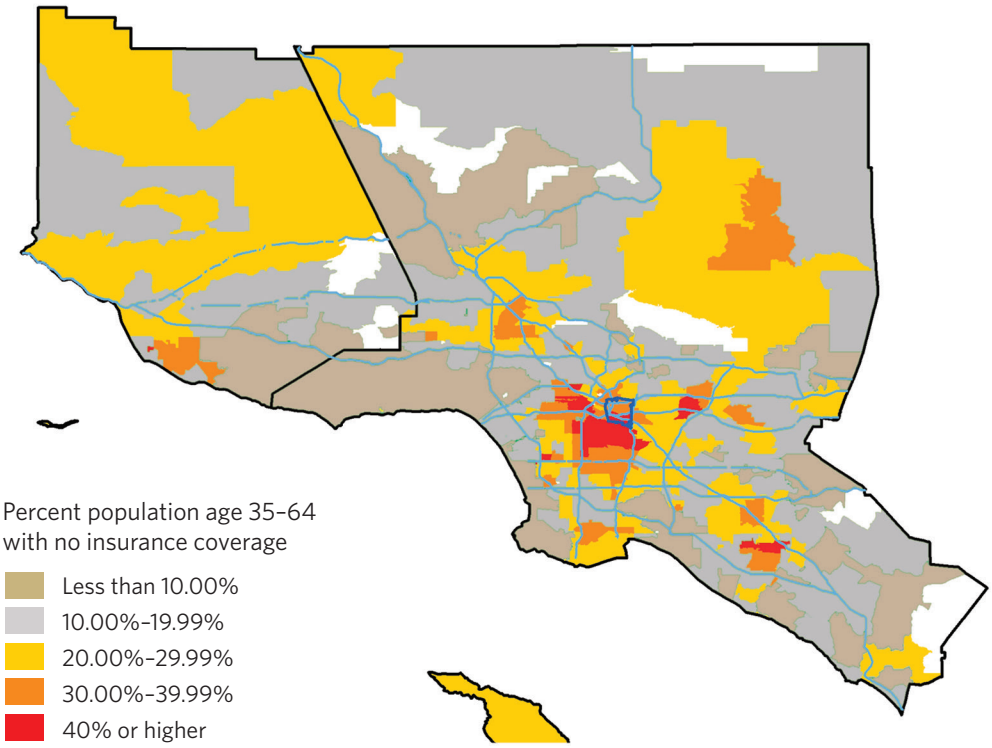


Figure 13: Percent population age 35–64 with no insurance coverage

- Less than 10.00%
- 10.00%–19.99%
- 20.00%–29.99%
- 30.00%–39.99%
- 40% or higher

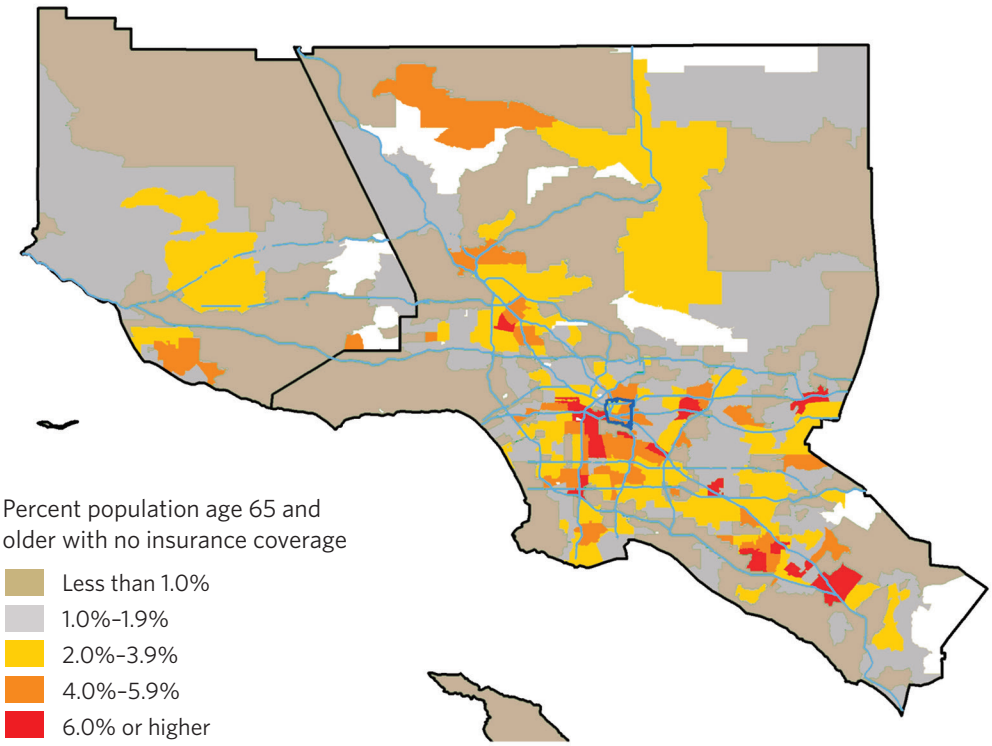


Figure 14: Percent population age 65 and older with no insurance coverage

- Less than 1.0%
- 1.0%–1.9%
- 2.0%–3.9%
- 4.0%–5.9%
- 6.0% or higher

observed, where Boyle Heights is a part of a larger number of communities with large uninsured populations. However, the severity for those 65 and older is more pronounced in South L.A., East San Fernando Valley and San Gabriel Valley, and a few communities in Orange County.

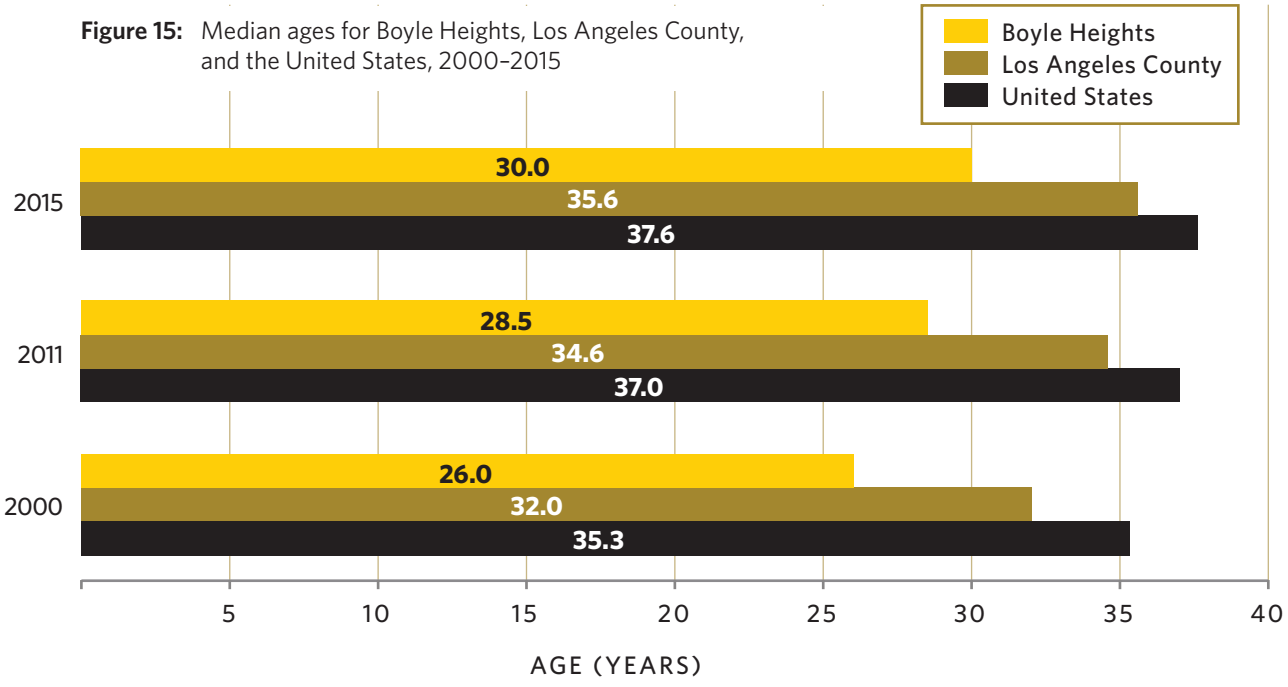
Reflections on Patterns and What the Future Might Hold

This brief analysis has clearly illustrated the importance of focusing on smaller geographies when considering health policies. Socioeconomic status, age, educational attainment, types of occupation and industry, as well as income, are mapped unevenly across American urban landscapes. As such, what might work at national and county levels may be less than effective in neighborhoods such as Boyle Heights. Since there is a close relationship between race, ethnicity and other demographic indicators, particular attention must be paid to methodologies that translate the impacts of policy shifts (e.g., access to health insurance) at smaller neighborhood levels.

Furthermore, given two important but inevitable changes in the near future, aging and uneven patterns of gentrification, it is important to consider these factors in determining policy options in a shifting demographic landscape. For example, over the last few decades, the median age of the nation as a whole has gradually increased (see Figure 15) from 35.3 in 2000 to 37.6 in 2015. This means that in a span of 15 years, the entire nation has become, on the average, older. For Los Angeles County, a similar shift has occurred from 32 to 35.6. While Boyle Heights is generally home to a slightly younger population, the median age has increased at a much faster pace, from 26 to 30. This means that within the next 20 years, it is possible that as the number of children decreases and the number of the elderly increases, the need for health insurance coverage types will shift as well. As such, policies need to remain nimble in order to accommodate this and other similar shifts.

Similarly, as ideologies, branding, and urban redevelopment agendas shift, so do the attention to and desire for certain neighborhoods. If the post-war era

Figure 15: Median ages for Boyle Heights, Los Angeles County, and the United States, 2000–2015



witnessed mass suburbanization of the population, the last twenty years has witnessed a desire among the younger, single and married without children, to return to downtowns and the older neighborhoods surrounding them. This pattern of population shift has accentuated what is called gentrification, and has resulted in population displacement. Many of the low-income and working-class people of color now live in older suburbs, where the infrastructure for public resources is limited. In fact, poverty has increased significantly in such geographies.

The lesson for policy making is to be aware of two conditions. On the one hand, it is important to pay attention to micro-geographies and community level dynamics in order to respond to what is 'now' and 'real'; on the other hand, it is also necessary to remember the structural dynamics that occur in shifting geographic landscapes, and therefore respond to the needs of people within specific socioeconomic categories. This simultaneous attention to place-based and people-based policies is an important step toward responding to both current and future needs.

From a purely health insurance and health care policy perspective, the issue of aging and graying of the nation should be considered fully. We need to be ready, and engage in planning for a much older population within the next 20 to 30 years. We have neither the necessary infrastructure nor the processes that would enable us to respond to the needs of this emerging population. In particular, we need to aware of the implications of aging in working class and low-income communities of color such as Boyle Heights.

Recommendations

Given the findings of this research, the following three recommendations are proposed:

1. Healthcare and health insurance policies need to consider and provide leeway for dealing with the differential socio-demographic dynamics of smaller geographies and neighborhoods. This requires particular methodologies and attention to small area analyses.
2. Policies aimed at access to health insurance and healthcare services should focus not just on current trends, but also on changing demographics and economic and social restructuring. Combined with the first recommendation, this requires both place-based and people-based analyses and policy considerations.
3. Aging is a looming reality facing the nation and many of its communities. It is crucially important that all policies related to healthcare and health insurance consider this demographic reality. This is particularly important for communities that are aging more rapidly than others.

About the Author

Ali Modarres, PhD is the Director of Urban Studies at University of Washington Tacoma. He is the editor of *Cities: The International Journal of Urban Policy and Planning* and serves on a number of research and policy advisory boards. He previously taught at California State University, Los Angeles and served as the Associate Director of the Pat Brown Institute for Public Affairs. Dr. Modarres earned his Ph.D. in geography from the University of Arizona and holds master and bachelor degrees in landscape architecture from the same institution. He specializes in urban geography and his primary research and publication interests are socio-spatial urban dynamics. He has published in the areas of social geography, immigration, urban development and planning policy.

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THE PAT BROWN INSTITUTE FOR PUBLIC AFFAIRS AT CAL STATE LA
5151 State University Drive
Los Angeles, California 90032-8002
PHONE: (323) 343-3770
www.patbrowninstitute.org