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Inequities in job-based health coverage for California low-wage workers

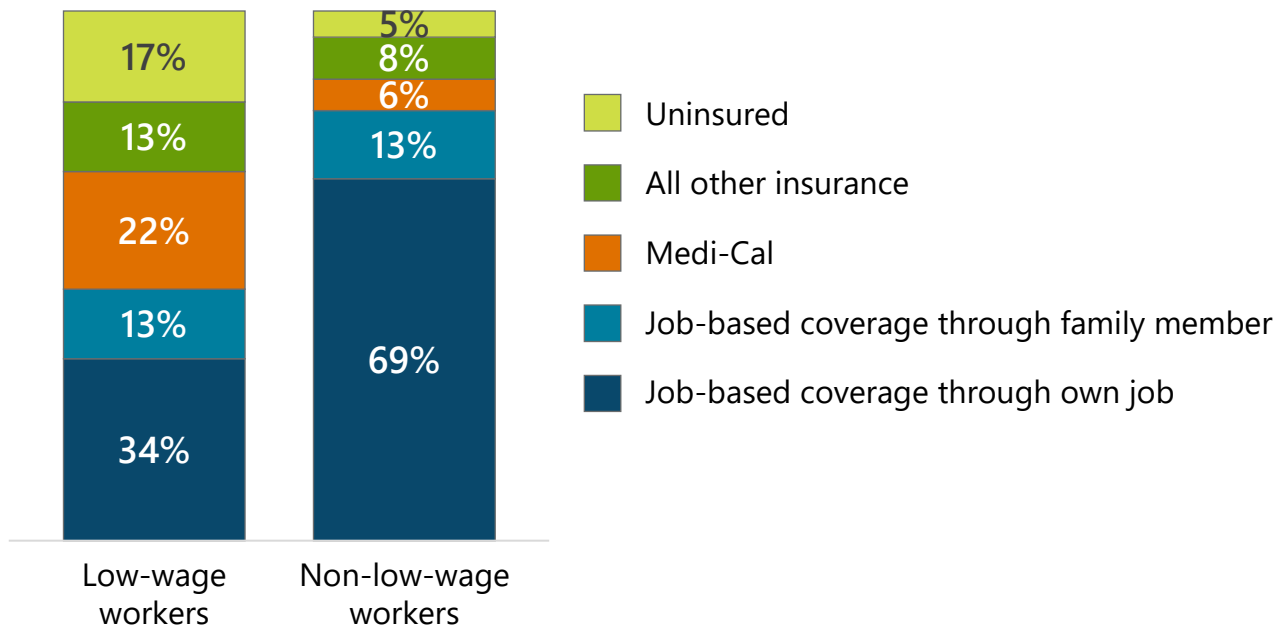
By Alexis Manzanilla, Savannah Hunter, and Miranda Dietz

Most Californians under age 65 receive health coverage through their or a family member's employer. Workers earning low wages, however, are far less likely to have job-based coverage, and more likely to be on Medi-Cal or uninsured. This creates a real public cost: California spends tens of billions in state and federal dollars covering low-wage workers through Medi-Cal. In the face of [federal Medicaid cuts](#) in H.R. 1, California must revisit the question of who bears responsibility for the health coverage of low-wage workers in a system that primarily relies on job-based coverage for working-age adults and their dependents. This brief examines the low-wage health coverage gap, its costs to the state, and possible policy options—drawing on lessons from other states—available to California lawmakers.

The job-based health coverage systems leaves gaps for low-wage workers

For decades, the health insurance system in California, as throughout the nation, has been dominated by job-based coverage. Health insurance through an individual's job or through the job of a family member is the [main coverage source for California adults 65 and below](#). Among California's non-self-employed workers age 16 and older, there is a notable difference in rates of job-based coverage between those paid [low wages](#) (less than about \$20 an hour in 2022) and non-low-wage workers. As seen in Figure 1, in 2022 69% of non-low-wage workers received health coverage through their own jobs, while just 34% of low-wage workers did. Compared to non-low-wage workers, low-wage workers were much more likely to be covered by Medi-Cal (22% vs. 6%) or be uninsured (17% vs. 5%).

Figure 1. Source of health insurance among California workers, 2022



Source: UC Berkeley Labor Center analysis of Current Population Survey, 2022

Note: Includes California non-self-employed workers age 16+. Does not account for survey undercount of Medi-Cal. Numbers may not add due to rounding.

There are three main reasons that workers might not have job-based coverage through their own job: their employers do not offer it, they are ineligible, or the associated costs (premiums, copayments, deductibles, etc.) are unaffordable. While the Affordable Care Act ([ACA](#)) [requires employers with 50 or more full-time employees to offer job-based health coverage](#) to their full-time employees or pay a penalty, smaller employers are not required to do so. As a result, many smaller businesses ([65% of California private-sector firms with fewer than 50 workers](#)) do not offer such benefits. At firms that do offer health insurance, some workers remain ineligible due to part-time status or waiting periods at the start of employment.

Even when workers are offered health insurance, it may be unaffordable. In 2025, the [average annual worker premium contribution in California](#) was \$1,300 for single coverage, and \$7,300 for family coverage. At most firms, the premium contribution is the same for all workers, regardless of their wages: the CEO and the administrative assistant pay the same amount. Nationally only 14% of large firms (those with 200 or more employees) reported offering a [reduced premium contribution for lower-wage employees](#). The cost of health insurance premiums can be prohibitive for workers paid low wages: for instance, a family of four with income at the poverty line (about \$32,000) would have to pay 23% of their income to cover the \$7,300 average health insurance premium contribution for

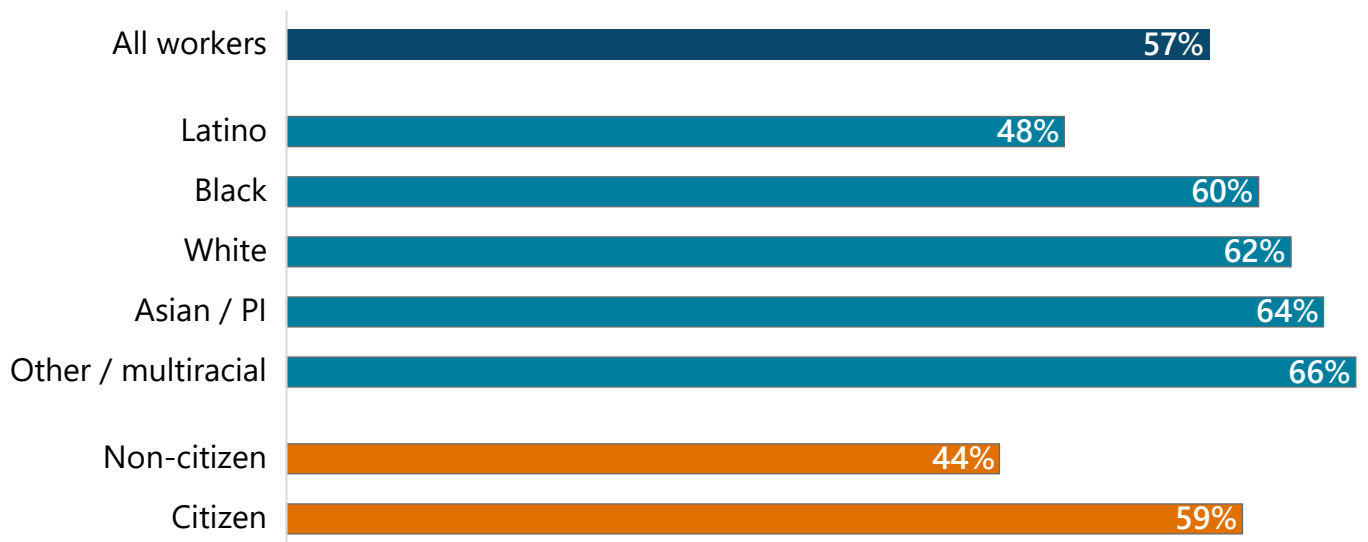
job-based coverage, not including a [likely deductible](#) and other out-of-pocket expenses. A single person at the poverty line would need to pay about 8% of their income for the average single premium contribution, and up to 19% of their income if they hit the [average full deductible](#). Affordability is a growing concern, as [premiums have increased substantially over time](#): Over the past two decades, family health care premiums for private-sector workers in California have grown faster than the state's median household income and faster than inflation.

Latino and non-citizen workers have especially low rates of job-based coverage

Among California's workers, rates of health coverage through one's own job vary not just by wages but also by race and immigration status. Figure 2 shows that workers who identify as Latino and those who are not citizens (including but not limited to those that are undocumented) are less likely than other workers to have job-based coverage through their own job.

Structural factors drive these disparities. Latino and non-citizen workers are disproportionately concentrated in low-wage occupations and in smaller firms that are less likely to offer coverage, contributing to [lower rates of job-based coverage](#).

Figure 2. Share of California workers age 19-64 enrolled in job-based coverage through their own job, 2025



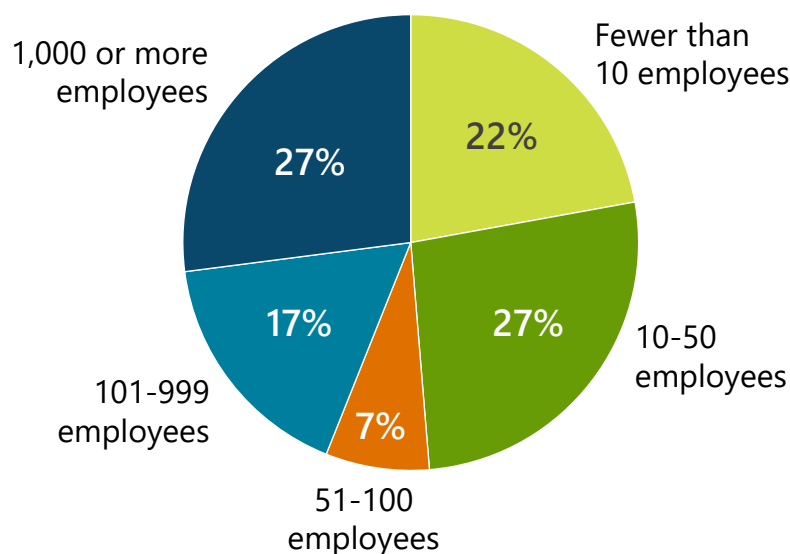
Source: UC Berkeley Labor Center analysis of 2025 Current Population Survey ASEC Supplement

Note: Includes California non-self-employed workers age 19-64.

Disparities in job-based coverage for low-wage workers have a real public cost

Employers' limited offers of affordable job-based coverage for low-wage workers result in significant Medi-Cal costs for the state and federal government and therefore the public. Approximately 3.6 million California workers—excluding those who are self-employed—receive health benefits through Medi-Cal. Using projected per-enrollee costs from the California Department of Health Care Services, the state will spend 36 billion in state and federal dollars on Medi-Cal coverage for non-self-employed workers.¹ These workers come from [a range of industries](#) and [occupations](#), with employers ranging from small local businesses to large multi-national corporations. Roughly half of workers in Medi-Cal are employed at firms with 51 or more workers, as shown in figure 3.

Figure 3. California workers age 19-64 enrolled in Medi-Cal by firm size, 2023-24



Source: UCLA California Health Interview Survey 2023-24

Note: Excludes self-employed workers

As [analyses across a range of industries](#) has shown, [low-wage, low-road business strategies come with real public costs](#). Policies to raise wages and labor standards, whether in [health care](#), [fast food](#) or in [the workforce generally](#) is one way to reduce these public costs, including Medicaid related costs.

¹ UC Berkeley Labor Center analysis of [DHCS Medi-Cal enrollment data for ages 19-64](#) from November 2025, DHCS Cost per Eligible in Fiscal Year 2026-2027 from [November 2025 Local Assistance Estimate](#), and data on work status and self-employment status from [UCLA California Health Interview Survey 2023-2024](#).

Some states are monitoring and attempting to address the public cost of gaps in job-based coverage

California is not the only state facing significant public costs due to gaps in job-based health coverage, and several states have implemented or are considering implementing laws to address the issue.

One approach is to collect data and monitor the problem. For a number of years, [New Jersey](#), [Nevada](#), and [Washington](#) have produced publicly available annual reports on which firms employ people who are enrolled in Medicaid, the number of employees' dependents on Medicaid, and the estimated cost to the state.

In the wake of federal Medicaid funding cuts, some states have considered employer fees based on Medicaid enrollment. In March 2026, New Jersey Governor Mikie Sherrill unveiled a state budget plan that included [a proposal to fine large employers](#) with workers on Medicaid, charging fees of up to \$725 annually for every person covered by the program. This budgetary proposal has [yet to be approved](#). [Washington, in a Senate Bill](#) introduced in January 2026 that since [failed to advance](#), proposed assessing a fee of over [\\$7,200 per year \(\\$600 per month per employee\)](#) on employers with workers enrolled in Medicaid. In [Colorado, a House bill](#) under consideration would assess large employers a \$2,300 annual fee per worker enrolled in Medicaid.

Other states have laws in place requiring contributions from employers to help fund public coverage. Vermont requires employers to contribute to the cost of providing health care for workers when the employer has more than four full-time equivalent (FTE) [uncovered employees](#)—including workers on Medicaid, those enrolled in the state marketplace, or those who are uninsured. The contribution is approximately [\\$300 per quarter](#) for a full-time uncovered employee in 2026. Since 1990, Massachusetts has assessed some form of [employer contribution for publicly funded healthcare](#). Massachusetts introduced the ongoing [Employer Medical Assistance Contribution \(EMAC\)](#) in 2014 for employers with six or more employees to fund public insurance programs in the state. Employers contribute up to \$51 per employee for all employees, regardless of their coverage status. In 2018, Massachusetts added a temporary two-year [EMAC Supplement](#) requiring employers to pay up to \$750 per employee for those enrolled in Medicaid or the state marketplace.

California is considering new reporting requirements and creating a new funding stream to mitigate Medi-Cal funding cuts

California is now considering both approaches. The Senate Democrats' 2026-27 budget framework proposes a "[Fair Share Contribution](#)" requiring large employers (the top 1-2% of corporations) to contribute to the cost of Medi-Cal for their workers. Another proposal would require public reporting on employers whose workers rely on Medi-Cal, including the associated cost to the state.²

The challenge of affordable coverage for low-wage workers is not new, but federal Medicaid cuts make it newly urgent. Low-wage workers in California are far less likely than other workers to have job-based coverage, and as a result roughly 3.6 million workers rely on Medi-Cal—at a projected cost of \$36 billion in state and federal dollars. As federal cuts under H.R. 1 combine with state budget pressures to threaten funding and coverage for millions enrolled in Medi-Cal, the state faces a choice: keep absorbing the costs alone, or ask employers to support the state's investment in health care coverage for their workers.

² Bills currently being considered include SB 1284, requiring employer reporting, and AB 2729, requiring employer contributions.

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UC Berkeley Labor Center

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