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ENSURING HEALTH COVERAGE FOR CALIFORNIA'S IMMIGRANT CHILDREN

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The New America Foundation is committed to achieving universal health insurance coverage for all people in America. The most promising route to universal coverage is a system that relies on shared responsibility among individuals, employers, and the government. To that end, the New America Foundation has released a series of three papers outlining how to cover all children in California as a first step towards universal coverage. This paper is a component of that series.

For many reasons, California's immigrant population poses unique challenges for policymakers seeking universal coverage. Poverty, jobs that fail to offer health insurance, immigration status, and federal and state policies that limit access to publicly-funded insurance all reduce health insurance coverage rates for immigrants. Nevertheless, immigrants are so central to the economy and society of California that any proposal that is serious about covering all children must include non-citizen children.

California's foreign-born population is much less likely to be enrolled in health insurance than its native-born population. In fact, Californians who are foreign-born comprise 27 percent of

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California's overall population, but 54 percent of the state's uninsured population.¹ Non-citizens represent 15 percent of California's population and 43 percent of California's uninsured.² Moreover, California children living in immigrant families are about three times as likely to be uninsured as children in families with all members born in the US. Undocumented immigrants and citizen children whose parents are undocumented are 1½ to 3 times more likely than other foreign-born residents to lack health insurance.³

This paper describes the current avenues and barriers to health insurance for California's immigrants and offers recommendations for improving access to care. It is intended to serve as a complement to the New America Foundation's proposal for covering California's children as a first step toward universal health insurance for all in California.⁴ Because immigrant families sometimes have unclear or mixed citizenship status and a tenuous connection to the formal labor market and tax system, careful consideration of how to meet this population's health insurance needs without exposing them to undue financial and legal burdens must be a part of any plan to extend health insurance to all children and, eventually, all Californians.

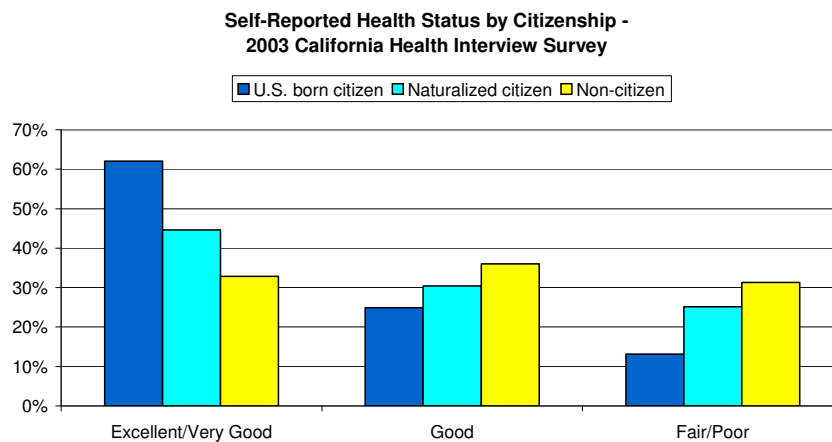
Under New America's proposal, we seek to promote a system of shared responsibility among individuals, government, and employers. Under this approach, the government would work to make insurance more easily accessible, more affordable, and then parents would have the responsibility of enrolling children in health insurance. At the same time, employers would be expected to maintain their support.

As this paper outlines, it is critical to assure that all immigrants in California have access to high quality health care through health insurance—something that is not true today. In the first part of this paper, there is a significant amount of data and factual background that is offered to help ground the reader. In the second half of the paper, we offer New America's ideas on how to achieve coverage for all of California's children, and in particular immigrant children, by creating a system of shared responsibility between the government, employers, and parents.

Why Health Insurance Matters

Without stable health insurance, access to regular preventive care can be challenging. Lack of health insurance or significant gaps in health insurance can expose families to financial risk and can cause delays in care until health emergencies arise.⁵ As discussed later in this paper, California's immigrants frequently face challenges that render health care a luxury that can only be accessed in the most dire circumstances, with financial, linguistic and cultural competency all serving as barriers to access. When care *is* accessed, these same factors also can diminish its quality far too often.

A recent series of reports by the Institute of Medicine details the high costs of being uninsured, both for individuals and for society as a whole.⁶ Indeed, immigrants in California without health insurance are at significantly greater risk for low health status, tend to have self-reported poor or fair health, and often lack a usual source of health care. Seeking care only when health problems deteriorate significantly impacts both the health status of these individuals and families and increases the strain on California's already fractured health system.



Source: New America Foundation analysis of 2003 California Health Interview Survey Data

In the California Health Interview Survey (CHIS) conducted in 2003, native-born citizens were more likely to report excellent or very good health than were naturalized citizens or non-citizens. When the results are narrowed to include only Californians living under 200 percent of the poverty level, the differences are reduced slightly; however, naturalized and non-citizens still report worse health. In addition, 7 percent of young children of immigrants are reported in fair or poor health by their parents, over twice the rate for children of natives (3 percent). More than twice as many young children of immigrants as natives lack a usual source of health care (8 percent versus 3 percent).⁷ A recent report by the University of California and the Mexican National Population Council suggests that there may be a length-of-stay gradient to immigrants' health status, with newly-arrived immigrants healthier than the native-born and reporting worse health than natives only after some years in the United States.⁸

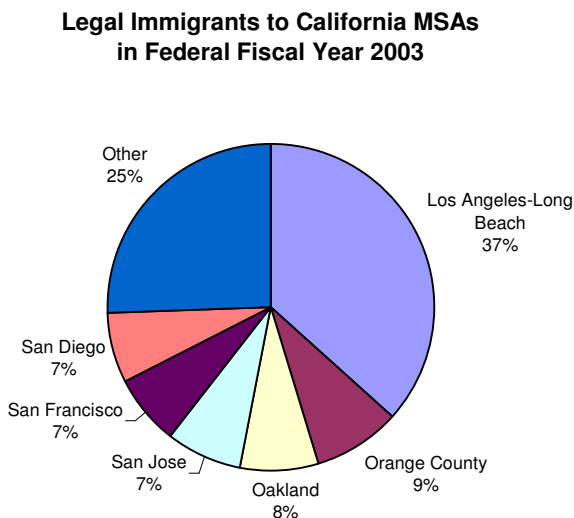
There is research suggesting that some cultural factors can lead immigrants to have higher health status than native-born persons (such as selection bias causing healthier persons to immigrate to the US and higher levels of outdoor activity); however, the reduced health coverage levels and socio-economic disadvantages lead immigrants to have an overall lower health status.⁹

Demographics of California's Immigrant Population

California's immigrant population is large, diverse, and predominantly low-income. The population is also growing swiftly: between 1980 and 2005, the number of immigrants in California increased from 3.6 million to 9.8 million.¹⁰ This number is projected to be 14.1 million by 2030.¹¹ As a share of the state population, the percentage of foreign-born surged from 15 percent in 1980 to 27 percent in 2005 and is projected to rise slowly, reaching 30 percent by 2030.¹²

California has a higher proportion of immigrants than any other state.¹³ In 2004, California attracted 27 percent of the nation's new immigrants, over twice as many as New York, the next largest immigrant-receiving state.¹⁴ Among all foreign-born residents in the United States, it is estimated that 44 percent are non-citizens living in the U.S. legally, 30 percent are naturalized citizens, and 26 percent are undocumented immigrants.¹⁵

In 2003, eleven of the top 50 legal immigrant-receiving Metropolitan Statistical Areas (MSAs) in the country were located in California. The Los Angeles-Long Beach MSA accounted for over a third of all legal immigration to California (see chart below).¹⁶ By far, the largest number of legal immigrants arrived from Mexico to California (29 percent). A significant number also arrived from Asian countries, including the Philippines, China, and India.¹⁷



Source: Urban Institute, “Undocumented Immigrants: Facts and Figures,” January 12, 2004.

California’s immigrant population is young, with more than half of the legal immigrants to California under the age of 35. Women make up 57 percent of legal immigrants, while they comprise about 40 percent of undocumented immigrants.^{18, 19}

Nearly all California immigrants are engaged in the paid workforce, but most are low-wage workers. Poverty rates are higher among immigrants than among native-born citizens, and almost all families with at least one undocumented parent are living under 200 percent of the federal poverty level (FPL).^{20,21} While data are limited on the income levels of residents with and without documentation, 30 percent of native-born citizens in California live below 200 percent of

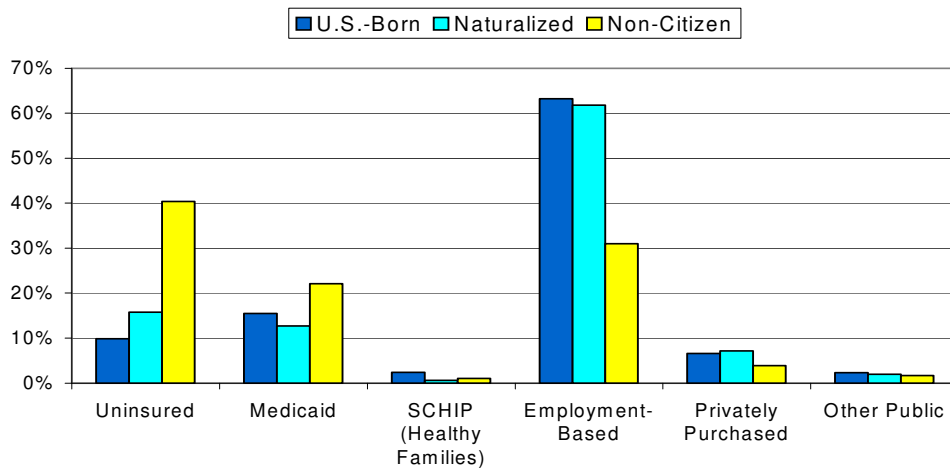
the FPL, while 38 percent of naturalized citizens and 71 percent of non-citizens live below 200 percent of the FPL, according to the CHIS 2003 data.²²

Policies focused on immigrants simultaneously affect citizens and non-citizens, as many families include both. Among the children of non-citizen parents, 72 percent are U.S. citizens, and 65 percent of the children of undocumented immigrants are citizens.^{23, 24} More than a quarter of uninsured non-citizen children have a sibling who is a U.S. citizen.²⁵

Health Insurance Access among the Immigrant Population

In each year from 2000 through 2004, over one-fifth of the nation’s uninsured were non-citizens. While the uninsured rate for the native population was 13.3 percent in 2004, the rate for the foreign-born population was over twice as high at 33.7 percent.²⁶ Of the foreign-born population nationwide, 17.2 percent of naturalized citizens were uninsured, compared to 44.1 percent of non-citizens.²⁷ In 2004, 26 percent of the total uninsured population in the U.S. was foreign-born—totaling 11.9 million persons.²⁸ It is worth noting that most uninsured non-citizens are legal residents.²⁹

**Current Health Coverage by Citizenship Status -
2003 California Health Interview Survey**



Source: New America Foundation analysis of 2003 California Health Interview Survey Data

This national phenomenon impacts California greatly because of the size and diversity of the state's immigrant population. California children living in immigrant families are significantly more likely to be uninsured than children in families with all members born in the US. Approximately 40 percent of California's non-citizens are uninsured, compared to 10 percent of the native-born.³⁰

Undocumented immigrants and citizen children whose parents are undocumented are the most likely to lack health insurance. Children of low-income immigrants are twice as likely to be uninsured as those of natives (22 versus 11 percent), despite a substantial increase in the coverage of low-income children of immigrants through Medicaid and other public programs between 1999 and 2002 (from 45 to 57 percent).³¹ The situation is even more challenging for undocumented immigrant children, 55 percent of whom were uninsured at some point in the year according to the 2001 CHIS.³²

Even when immigrant children are insured, they may not access adequate care. According to a recent study in the *American Journal of Public Health*, health expenditures for immigrant children nationally were 74 percent less than those of native-born children in 1998, and immigrant children received 72 percent fewer medicines than native-born children.³³

There is also extensive anecdotal evidence to support the conclusion that immigrants have less access to the health system than citizens. As reported in the *Wall Street Journal*, staff at Stockton, California's San Joaquin General Hospital only see undocumented workers when illnesses have become emergencies: "[W]omen often wait until they're eight or nine months pregnant to seek prenatal care. Men show up almost exclusively in the emergency room. Often, as in the recent case of a migrant worker with advanced testicular cancer, they come too late."³⁴ However, this does not imply that immigrants use emergency rooms more frequently than the native-born; in fact, recent immigrants visit ERs about half as much as US-born whites.³⁵

Current Avenues and Barriers to Health Insurance for California's Immigrant Population

California's immigrants have access to a number of sources of health coverage.

Employer-Sponsored Health Insurance

In the state and the nation, most people are covered through employer-sponsored health insurance. However, many Californian immigrants hold jobs that do not offer insurance, and they are less likely to purchase insurance when it is offered as a benefit.³⁶ Ironically, these low-wage workers are often employed in the most dangerous professions, such as farm and factory work. Due in part to labor force patterns, legal and undocumented immigrants are less likely than the native-born to keep health insurance if they have it, or to gain coverage if they are uninsured.³⁷ Cross-border health plans—offered by Blue Shield of California, Health Net, and Mexico-based SIMNSA—insure approximately 150,000 California workers.³⁸

Variation in Employer-Sponsored Insurance Offer Rates, Eligibility, and Take-Up Rates Available to California's Employees³⁹

	Offer	Eligibility	Take-up
All employees (12,984,000)	83.4%	90.8%	84.4%
Race/Ethnicity			
White	88.8%	91.1%	83.3%
Latino	70.4%	88.7%	81.9%
Asian American & Pacific Islander	84.1%	92.0%	84.8%
African American	90.7%	91.8%	88.1%
American Indian & Alaska Native	81.8%	89.5%	82.1%
Citizenship Status			
U.S.-born Citizen	88.6%	90.3%	84.9%
Naturalized Citizen	84.2%	93.9%	84.5%
Noncitizen With Green Card	71.8%	89.5%	81.4%
Noncitizen Without Green Card	50.4%	90.1%	81.1%

While the chart above shows that there is relatively little variation in eligibility and take-up rates by citizenship status, there are significant discrepancies in the offer rates. Although 88.6 percent of native-born citizens are offered employer-sponsored insurance, only 50.4 percent of non-citizens without documentation are offered such insurance. Still, the high take-up rates even for this sub-group suggest that immigrant workers value health insurance, they just do not have the same access to it nor the same ability to afford it as citizens. Thus, a partial subsidy might be particularly effective for the majority working immigrant population, and this is the kind of shared responsibility approach to coverage expansion New America envisions.

Medi-Cal

No-cost Medi-Cal is currently available for very low-income children and parents. Undocumented or recent immigrants may only access Medi-Cal coverage for emergency, long-term, dialysis, and pregnancy-related care. Out of a total of approximately 2.4 million undocumented immigrants in California during fiscal year 2003-2004, an estimated 200,000 children used these services at a cost of \$75.5 million.⁴⁰

Many of the immigrants who could access free Medi-Cal coverage do not do so, due to fear of jeopardizing immigration status, lack of knowledge, language barriers, or other access issues. Two-thirds of native-born children in families with undocumented immigrant parents are uninsured yet Medi-Cal eligible, compared to one-third of native-born children with native-born parents.⁴¹ Immigration status information provided on a Medi-Cal application is confidential and cannot be used against the applicant for immigration enforcement or deportation unless Medi-Cal fraud is suspected. In fact, California accepts a signed declaration as proof of citizenship for Medi-Cal applicants; only post-eligibility quality control efforts or suspicious evidence would betray an undocumented immigrant who applied for Medi-Cal.⁴²

Healthy Families

The Healthy Families program—California’s version of the national State Children’s Health Insurance Plan (SCHIP)—covers children in slightly higher income families (as compared to the Medi-Cal program). Immigration requirements for the Healthy Families Program are similar to

the Medi-Cal program. However, as discussed below, states now have the option of covering prenatal care for mothers of any immigration status.

In 2001, 28 percent of native-born California children with at least one undocumented immigrant parent, and 36 percent of native-born children in native-born families, were uninsured but Healthy Families eligible.⁴³ This relatively high take-up rate suggests that the Healthy Families Program may have more success in reaching out to eligible immigrants, or perhaps that the program carries less stigma than Medi-Cal. The eligibility rules are also different between Medi-Cal and Healthy Families. Also for 2001, a full two-thirds of native-born children in families with at least one undocumented immigrant parent were uninsured yet Medi-Cal eligible, as compared to one-third of native-born children with native-born parents who were uninsured yet Medi-Cal eligible.⁴⁴

Barriers for Immigrants in Public Programs

The most significant barrier to enrollment in public health insurance is a culture of confusion and fear around the availability of coverage for immigrants. Many immigrants do not sign up for the publicly-funded health insurance to which they may be entitled out of fear or distrust. Public opinion about legal and undocumented immigrants, as reflected in law, can be unpredictable and can appear to be hostile to immigrants.

For example, in the early 1990s, many immigrants feared that using Medicaid would cause them to be labeled a “public charge” by the federal government, which created fear among immigrants of becoming ineligible for citizenship, being deported, and facing denial of re-entry to the United States for individuals who left voluntarily.⁴⁵ There are also concerns about the use of public benefits having negative ramifications for an immigrant’s sponsors. And many immigrants believe that they are not eligible for Medi-Cal due to the publicized changes at the federal level prohibiting the use of federal funding to provide care to legal immigrants during their first five years in the country for non-emergency Medicaid and SCHIP provided to legal immigrants.⁴⁶

The confusion around the federal rules and the resulting fear are more of a barrier to accessing health care than the law itself. For example, federal policy in 1999 clearly explained that use of Medicaid or SCHIP does not affect the public charge determination; the confusion and fear of being so labeled has caused a lingering distrust of government health benefits.⁴⁷ In addition, in California, the state has used state-only funds to cover those under Medi-Cal who are otherwise eligible except for the five-year ban.

It is true that some recent policy changes assist the immigrant population. The U.S. Department of Health and Human Services issued a regulation in the fall of 2002 allowing states to use SCHIP funds for low-income women's prenatal care without regard to immigration status.⁴⁸ Under this option, prenatal care is covered even if the mothers are undocumented or recent immigrants.⁴⁹ As of February 2005, seven states—Michigan, Washington, Massachusetts, Rhode Island, Minnesota, Illinois, and Arkansas—have already implemented the option.⁵⁰

However, this effort cannot overcome the other messages on immigrant health coverage. More specifically, in California, voters passed Proposition 187 in 1994 to ban any publicly-funded services for unauthorized immigrants (although it was later deemed unconstitutional). Since it was never implemented, there have been subsequent Proposition 187-type ballot initiatives and legislative amendments; though these attempts have been defeated, proponents have vowed to persist. Of particular concern are the documented children of undocumented parents. Many times, parents will forgo seeking benefits to which their children are entitled if they themselves are undocumented or if there is an undocumented sibling.

Also, in at least one California county, it was reported that enrollment workers requested the Social Security number of parents when they applied for public health insurance for their child—even though federal regulations specify that only the *applicant's* Social Security number can be requested.⁵¹ It is documented that this happened nationwide among eligibility workers. While governments cited confusion in the federal rules and the need for time to update enrollment systems, advocates for the uninsured asserted that the policy was intentionally designed to have a chilling effect on immigrant applicants.

These families live in fear of being deported, and it can make accessing government services a traumatic experience that many would rather forgo instead of obtaining needed services to which they have a legal right to claim.

Other Sources of Health Insurance for Immigrants

There are additional sources of insurance coverage for immigrant families.

Children's Health Initiatives

Eleven California counties are combining public, non-profit, and private money to fund low-cost health, dental, and vision coverage plans for children who are ineligible for Medi-Cal and Healthy Families due to immigration status or family income above the guidelines (up to 300 percent of the federal poverty level, with one county operating up to 400 percent).⁵² Another 18 counties are in the planning stage of such projects.⁵³ These plans, collectively called Children's Health Initiatives (CHIs), also operate aggressive outreach and enrollment efforts for the existing Medi-Cal and Healthy Families plans. In fact, by June 2005, the existing CHIs estimated that they had helped enroll 150,000 children in health insurance.⁵⁴ The largest CHI is in Los Angeles; it had almost 40,000 enrollees as of April 2005 and relies heavily on charity funds.⁵⁵

One of the best known CHIs is in Santa Clara County. The first of its kind in California, this program pioneered enrollment simplification procedures for families applying to Medi-Cal and Healthy Families. Previously, parents had to navigate the complex enrollment rules for various public programs; some families would face especially difficult enrollment challenges, such as those in which program eligibility would vary from child-to-child based on age, family income or immigration status. Under the CHI, the family is asked one set of enrollment questions, and children are enrolled in the appropriate program.

In addition, Santa Clara CHI operates an insurance plan called Healthy Kids that covers children who do not qualify for Medi-Cal and Healthy Families. In fact, Healthy Kids provides coverage to children whose families earn up to 300 percent of the federal poverty level and who are ineligible for existing public health insurance programs for other reasons, such as immigration status.

The Santa Clara CHI is currently undergoing a comprehensive evaluation. Findings suggest that the typical child enrolled in Healthy Kids is between the ages of 5 and 12, in good health, and Latino—with Latinos comprising more than 80 percent of total enrollment.⁵⁶ The program has accepted more than 100,000 enrollment applications,⁵⁷ and it has been credited with enrolling 13,500 children into Medi-Cal and Healthy Families that otherwise would not have been enrolled.⁵⁸ The program results are impressive, showing that:⁵⁹

- Unmet medical and dental need has been reduced (22 percent to 10 percent and 20 percent to 9 percent, respectively);
- The percentage of children with a usual source of care has nearly doubled for medical care (50 percent to 89 percent) and nearly tripled for dental care (29 percent to 81 percent);
- Use of medical care has increased significantly for well-child (24 percent to 43 percent), sick-child (16 percent to 30 percent) and specialty (4 percent to 11 percent) visits; and
- Parents' confidence in their ability to get their children needed care nearly doubled (43 percent to 75 percent).

CalKids and Kaiser Permanente

Among private insurers in California, only Kaiser Permanente and CalKids offer low-cost subsidized health insurance products for undocumented immigrants. Kaiser Permanente's Child Health Plan-2 is a pilot program providing subsidized coverage to children in their California service area, regardless of immigration status.⁶⁰ CalKids, a nonprofit that subsidizes insurance for low-income children who don't qualify for public programs due to immigration status, has provided subsidized insurance for more than 62,000 mostly Latino children in the Los Angeles area.⁶¹ CalKids is supported by private grants and donations. While these efforts are admirable, they are localized and dependent on the goodwill and healthy portfolios of private foundations.

Sources of Indirect Support

Many state programs in California help health care providers defray uncompensated care costs, including costs incurred by uninsured immigrants. While the vast majority of these programs do not specifically support immigrant care alone, they do bolster the strained network of providers who offer free or low-cost services to immigrants and other Californians.

The cornerstone of support is the Emergency Services and Supplemental Payments (ESSP) Fund, commonly known as the SB (Senate Bill) 1255 program. Under a new federal waiver effective September 2005, this program will evolve into the new Safety Net Care Pool for public hospitals. Historically, the program has received voluntary transfers from public sources to match with federal funds for distribution to safety net hospitals through negotiations with the California Medical Assistance Commission. In 2004-2005, the program spent about \$1.9 billion in funding.⁶² Under the new program, there is considerable uncertainty in future funding. However, it is anticipated that the same level of funding will continue at least through 2008, with the possibility of increased funding in the short term.

In addition, the Disproportionate Share Hospital (DSH) program, commonly known as the SB 855 program, provides roughly \$2 billion a year in supplemental Medi-Cal dollars to California hospitals with a large percentage of Medi-Cal, low-income, and uninsured patients. These funds, comprised of both federal and state money, are the lifeblood of many public hospitals. There are several programs that help support clinics as well, and California's counties dedicate significant resources to the care of the indigent, regardless of immigration status.

There are also important programs that support the public infrastructure for clinics such as the Child Health and Disability Prevention (CHDP) Program, Expanded Access to Primary Care (EAPC) Program, and SAMW (Seasonal and Migrant State Grants). The CHDP Gateway also serves as a critical outreach tool by allowing children to be presumptively eligible for Medi-Cal. Counties also operate indigent care programs that spend over a billion dollars a year on health care to the uninsured.

In addition, Section 1011 of the Medicare Modernization Act (MMA), entitled “Federal Reimbursement of Emergency Health Services Furnished to Undocumented Aliens,” provides \$250 million in federal dollars to states each year from 2005 to 2008 for reimbursement of emergency care for undocumented patients. California received \$70.8 million in 2005, which is being distributed directly to hospitals to offset unreimbursed costs for emergency inpatient, outpatient, and ambulance care for undocumented patients. Allocations were made based on the state’s percentage of estimated undocumented immigrants, and the number of apprehensions of undocumented immigrants made by the top six states.⁶³

According to the Centers for Medicare and Medicaid Services (CMS) calculations accompanying state allocations, California received 28 percent of the available funds, but is home to 32 percent of the nation’s undocumented immigrants. Only Arizona, New Mexico, and Texas received a portion of federal funding exceeding their state’s percentage of undocumented immigrants.⁶⁴ Hospitals receiving the funds must collect information about patients’ immigration status “indirectly,” meaning that while hospital staff are not required to ask patients outright about citizenship status, there are questions related to citizenship that CMS has required. Some California hospitals have protested these requirements as both an administrative burden and a barrier to patient trust, and this is likely to be a matter of ongoing debate.

Beyond the MMA, Senators John Cornyn (R-Texas) and Jon Kyl (R-Arizona) have introduced a bill that would establish temporary work permits for undocumented immigrants and would require their employers to provide them with health insurance.⁶⁵ However, the bill is not expected to gain Congressional support.

The New America Foundation’s Shared Responsibility Approach to Improving Access to Health Insurance

A cornerstone of the New America Foundation’s view of health policy is that everyone should have affordable health insurance that ensures access to high-quality care. However, our piecemeal health insurance system leaves too many families out. Because immigrants and, more specifically, non-citizens, are overrepresented among California’s uninsured, additional options and support are needed to give parents the opportunity to insure their children.

The New America Foundation’s proposal for covering all children is fully discussed in the first paper of this series, “Shared Responsibility.” Without duplicating that discussion here, our proposal adds to the existing discussion by establishing a buy-in pool for children without access to employment-based coverage or public programs. Immigrant families could buy into Healthy Families, under guaranteed issue rules and at an actuarially fair community rate. Families at any income could buy into Healthy Families, and low to moderate income families would be subsidized.

The proposal has several key elements:

- Uniform benefits and care delivery: All children in the buy-in pool will have access to uniform cost-sharing. There will be no means of distinguishing the immigration status of a child enrolled in the health coverage program.
- Building on the current system: Those using Medi-Cal, Healthy Families, and private insurance would be able to continue to do so as they do today.
- Uniform subsidy stream: Fairness requires that undocumented children receive the same subsidies for health care as documented children. This is fair for both the taxpayer, who ends up paying more when undocumented children seek care in emergency rooms; and it is fair with regard to all children.
- Safe haven: California’s CHIs have been very successful in offering a seamless system of coverage for undocumented children and families. By creating a one-stop-shop where families can apply for public health insurance free of fear, California’s counties have had a tremendous positive impact on coverage. This model should be central to any effort to extend health insurance to additional immigrant children and adults.
- Outreach: Any successful policy will require a strong outreach component. The New America Foundation’s paper *Covering California’s Children First: A Key Step on the Road to Universal Health Insurance* outlines several steps based on the work of the 100% Campaign and others that are needed to ensure a successful program to enroll immigrant children.⁶⁶

The most critical aspect of the New America approach as it relates to immigrant children is the creation of a buy-in pool. As of May 2004, 21 states used their own dollars to cover some non-citizens ineligible for federal matching funds.⁶⁷ And within California, AB 772 (Chan/Frommer) and SB 437 (Escutia) proposed enrolling children into Medi-Cal and Healthy Families look-alike programs at appropriate levels. AB 772 was passed by the legislature on September 8, 2005 and was vetoed by the governor in early October 2005. While this is a viable approach for policymakers, for the reasons described below we believe that a Healthy Families look-alike buy-in pool would be a preferable option.

- Actuarial stability: Having a catch-all pool not just for immigrant children but for all children who lack coverage increases the actuarial stability of the pool. Reducing the number of children covered or segmenting the population increases the possibility of instability.
- Keeping families together: A single pool keeps children who are in the same family in the same program.
- Medi-Cal's low provider reimbursement rates: Expanding Medi-Cal would put more financial pressure on providers.

Conclusion

Many challenging and controversial questions face policymakers who consider expanding health coverage to immigrants. Because a disproportionate share of California's uninsured is comprised of immigrants, any proposal to extend coverage to all Californians must consider the circumstances of this diverse group. All the advantages of universal coverage—better health outcomes and more economic productivity, an end to cost-shifting to the private sector, better organization of care delivery modes—will be lost if the large immigrant population in California is left out. Thus, the extra effort required to cover them will pay off in the long run.

Endnotes

- ¹ California Health Interview Survey, Data pulled from interactive website featuring 2003 CHIS data on 8/16/05. <http://www.chis.ucla.edu/>
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²⁸ Census Bureau 2004 Report, Table HI09: Health Insurance Coverage Status by Nativity, Citizenship, and Duration of Residence for All People, 2005. http://pubdb3.census.gov/macro/032005/health/h09_000.htm

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³³ Mohanty, et al. “Health Care Expenditures of Immigrants in the United States: A Nationally Representative Analysis.” *American Journal of Public Health*. August 2005, volume 95, number 8.

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³⁶ Alker, Joan C. and Marcela Urrutia, “Immigrants and Health Coverage: A Primer,” Health Policy Institute, Georgetown University, and the National Council of La Raza, prepared for the Kaiser Commission on Medicaid and the Uninsured. June 2004.

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³⁷ See, for example, Prentice, Julia C, MSPH and Anne R Pebley, PhD, Differences In Health Insurance Transitions Between Immigrants and the Native-Born, November 18, 2003.

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³⁸ Skidmore, Sarah, “Cross-Border Health Insurance is a Hit with Employers and Workers,” *San Diego Union-Tribune*, October 16, 2005. <http://www.signonsandiego.com/news/business/20051016-9999-mz1b16mexico.html>

³⁹ Chart taken from: E. Richard Brown, “Access to Care and Health Care Disparities in the Golden State”, Presented at “The California Endowment Health Journalism Fellowships San Francisco, University of California at Los Angeles, December 15, 2004. Based on 2001 CHIS data.

⁴⁰ Statements based on an analysis provided by the Department of Health Services to the New America Foundation. The aid codes considered are: 3T, 3V, 48, 58, 5F, 5T, 5Y, 69, 6U, 74, 7C, 7K, 8N, 8T. The data source is the MCSS 10% Sample Claims merged data base, calendar year 2003, version 1/5/05. Specific findings are:

- Age 1-5: 36,214 average monthly eligibles for a total cost of \$15,948,449.
- Age 6-17: 163,453 average monthly eligibles for a total cost of \$59,622,879.

⁴¹ Pourat, Nadereh, Gabrielle Lessard, Armine Lulejian, Lida Becerra, Rini Chakraborty, Demographics, Health, and Access to Care of Immigrant Children in California: Identifying Barriers to Staying Healthy, March 2003. http://www.healthpolicy.ucla.edu/pubs/files/NILC_FS_032003.pdf

⁴² Forty-seven states do not require documentary proof of citizenship for a Medicaid application.

⁴³ Pourat, Nadereh, Gabrielle Lessard, Armine Lulejian, Lida Becerra, Rini Chakraborty, Demographics, Health, and Access to Care of Immigrant Children in California: Identifying Barriers to Staying Healthy, March 2003. http://www.healthpolicy.ucla.edu/pubs/files/NILC_FS_032003.pdf

⁴⁴ Pourat, Nadereh, Gabrielle Lessard, Armine Lulejian, Lida Becerra, Rini Chakraborty, "Demographics, Health, and Access to Care of Immigrant Children in California: Identifying Barriers to Staying Healthy," March 2003. http://www.healthpolicy.ucla.edu/pubs/files/NILC_FS_032003.pdf

⁴⁵ Alker, Joan C. and Marcela Urrutia, "Immigrants and Health Coverage: A Primer," Health Policy Institute, Georgetown University, and the National Council of La Raza, prepared for the Kaiser Commission on Medicaid and the Uninsured. June 2004. <http://www.kff.org/uninsured/loader.cfm?url=/commonspot/security/getfile.cfm&PageID=44857>

⁴⁶ The five-year ban does not apply to selected groups, such as certain refugees and immigrants with disabilities. However, the welfare legislation also narrowed immigrants' eligibility for health coverage in several ways outside the five-year ban. First, when the five-year ban ends for an immigrant, the immigration sponsor's income and assets can be taken into account in determining the immigrant's eligibility for Medicaid and SCHIP. Second, before welfare legislation, federal funding was provided for immigrants who were Permanent Residents Under Color of Law (PRUCOL) – that is, residing in the U.S. with the knowledge and permission of federal immigration authorities. The welfare bill limited federal funding to certain, narrowly defined immigration categories, excluding a small number of PRUCOL immigrants who previously qualified for federally matched health coverage. See Families USA, *Immigrants' Eligibility for Medicaid and CHIP*, February 2001, <http://www.familiesusa.org/site/DocServer/immigrants.pdf?docID=365>; Leighton Ku and Bethany Kessler, The Number and Cost of Immigrants on Medicaid, December 16, 1997, <http://www.urban.org/urlprint.cfm?ID=6233>

⁴⁷ Letter to State Medicaid Directors, Health Care Financing Administration, May 26, 1999. <http://www.cms.hhs.gov/schip/sho-letters/ch052699.asp>

⁴⁸ SCHIP funding is a federal-state partnership, with 65 - 85 percent federal match depending on the state.

⁴⁹ U.S. Department of Health and Human Services. "States May Provide SCHIP Coverage For Prenatal Care." HHS News. September 27, 2002. <http://www.cms.hhs.gov/schip/whitehouse/unborn.pdf>

⁵⁰ California Legislative Analyst's Office, Analysis of the 2005-06 Budget Bill: Accessing Federal Funds for Prenatal Services, February 2005. http://www.lao.ca.gov/analysis_2005/Health_ss/hss_02_cc_prenatal_anl05.htm

⁵¹ The Consumer Health Alliance, "More Success Stories," downloaded September 5, 2005.

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⁵² Institute for Health Policy Solutions, California Children's Health Initiatives Implementation Map, downloaded September 7, 2005. http://www.ihps-ca.org/localcovsol/cov_initiatives.html#map

⁵³ Institute for Health Policy Solutions, California Children's Health Initiatives Implementation Map, downloaded September 7, 2005. http://www.ihps-ca.org/localcovsol/cov_initiatives.html#map

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⁵⁵ Institute for Health Policy Solutions, "Overview of Local Children's Coverage Expansions," June 9, 2005. www.ihps-ca.org

⁵⁶ Trenholm, Christopher et al., "Santa Clara Healthy Kids Program Reduces Gaps in Children's Access to Medical and Dental Care", Evaluation of the Santa Clara Health Initiative, Number 2, April 2005. http://www.ihps-ca.org/resources/_pdfs/chihealthykidsMPR.pdf

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⁵⁹ Trenholm, Christopher et al., “Santa Clara Healthy Kids Program Reduces Gaps in Children’s Access to Medical and Dental Care”, Evaluation of the Santa Clara Health Initiative, Number 2, April 2005. http://www.ihps-ca.org/resources/_pdfs/chihealthykidsMPR.pdf

⁶⁰ See <http://www.100percentcampaign.org/resources/publications/otr-child-health-programs.htm#kaiser> and http://www.ladpss.org/dpss/health_care/children_youth/kaiser_permanente_cares_for_kids.cfm

⁶¹ Melnick, Glenn, PhD, Joyce Mann, PhD, LaVonna Blair-Lewis, PhD, Susan Maerki, MHSA, MAE, Lois Green, MHSA, & Nasreen Dhanani, PhD, “Evaluation of the Los Angeles CalKids Program”, February 2002. <http://www.chcf.org/documents/policy/CalKidsEvaluationExecSummary.pdf>

⁶² CA Medical Assistance Commission Annual Report to the Legislature 2005

⁶³ A detailed discussion of the formula is available from the Centers for Medicare and Medicaid Services at <http://www.cms.hhs.gov/providers/section1011/cms10130.pdf>. The term “apprehensions” is defined by the Department of Homeland Security as, “The arrest of a removable alien by the Department of Homeland Security. Each apprehension of the same alien in a fiscal year is counted separately,” which is available at <http://uscis.gov/graphics/shared/statistics/standards/stdfdef.htm>. In relevant part, the law reads as follows:

“(2) BASED ON NUMBER OF UNDOCUMENTED ALIEN APPREHENSION STATES.—

IN GENERAL.—Out of the amount appropriated under subsection (a) for a fiscal year, the Secretary shall use \$83,000,000 of such amount to make allotments, in addition to amounts allotted under paragraph (1), for such fiscal year for each of the 6 States with the highest number of undocumented alien apprehensions for such fiscal year.

DETERMINATION OF ALLOTMENTS.—The amount of the allotment for each State described in subparagraph (A) for a fiscal year shall be equal to the product of—

- the total amount available for allotments under this paragraph for the fiscal year; and
- the percentage of undocumented alien apprehensions in the State in that fiscal year as compared to the total of such apprehensions for all such States for the preceding fiscal year.

DATA.—For purposes of this paragraph, the highest number of undocumented alien apprehensions for a fiscal year shall be based on the apprehension rates for the 4-consecutive-quarter period ending before the beginning of the fiscal year for which information is available for undocumented aliens in such States, as reported by the Department of Homeland Security.”

⁶⁴ Calculations from Center for Medicare and Medicaid Services document entitled “Final FY 2005 State Allocations for Section 1011 of the Medicare Modernization Act,” available at http://www.cms.hhs.gov/providers/section1011/fy05_state_alloc.pdf

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