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Health Coverage and Care for Undocumented Immigrants in California

An Update

SUMMARY

CONTENTS

Technical appendices to this report are available on the PPIC website.

California policymakers continue to weigh strategies for making health insurance universal and health care accessible to all—including for undocumented immigrant residents. The state expanded Medi-Cal to undocumented children and young adults using mostly state funds, and budget negotiations are underway to expand coverage to older undocumented adults. While coverage for all undocumented immigrants has been on the legislative agenda for several years, COVID-19 has underscored how gaps in health insurance coverage for immigrants, fear and avoidance of health care systems, and lack of access to vaccines can have consequences for entire communities.

This report updates PPIC's past work on health care and insurance coverage for undocumented immigrants, from presenting updated uninsured rates among immigrant groups to unpacking systematic differences in health care access by documentation status. We also examine aspects of how children in mixed-status families—where at least one member is undocumented—engage with the health care system. Situating these topics amid the shifting federal and state contexts of the past five years, including the pandemic, we find that:

- Uninsured rates are high for low-income undocumented immigrants. Uninsured rates for those older than 50 are especially concerning given higher levels of health care need.
- The health care safety net serving undocumented immigrants is uneven across geography, by age group, and in some cases by health needs.
- Undocumented immigrants and their family members do not use more emergency department services than other immigrants; lack of connections to the health care system is a greater concern.
- Children in families with at least one undocumented member are almost 11 percent less likely to have a usual source of care compared to children in other immigrant families, although they get health care at similar rates.

Questions remain around how to improve access to health insurance coverage and medical care for undocumented immigrants and their families. Current legislation proposes further expansion to cover all low-income adults regardless of immigration status. Expanding affordable insurance options—such as Medi-Cal expansion for older adults and the option to buy health insurance through Covered California—could begin to fill in the gaps for this group.

In addition to coverage expansions, incentivizing all counties to serve undocumented immigrants in their programs for the medically indigent and increasing supports for safety net providers could improve equity in accessing medical care. Finally, outreach to immigrant communities through community-based organizations and other trusted messengers would begin to alleviate some of the fear many undocumented immigrants and their family members

have surrounding government programs. These efforts would be consistent with the changing sentiments of state residents. In California, public support for inclusive health care coverage is growing—66 percent of adults supported health care coverage for undocumented immigrants in 2021, up from 54 percent in 2015 (Baldassare et al. 2021).

Introduction

California is home to about 10.6 million immigrants, about 80 percent of whom are naturalized citizens or legal permanent residents who have "green cards." Between 2 and 2.6 million are estimated to be undocumented—meaning they entered the country without authorization or stayed after a visa expired (see Technical Appendix A). A lack of good data sources means we know relatively little about this group of immigrants (Van Hook et al. 2015). In most cases, however, immigration status severely limits access to safety net programs for undocumented residents.

The pandemic has underscored the critical role that access to health care plays, not just for an individual's well-being, but for entire communities. We have also learned how interconnected individuals are, and we have seen that the vulnerability of some groups can lead to health risks for others. Undocumented immigrants, because they engage less with the health care system and may be deterred from doing so by immigration-related fears, could be a weak link in vaccination and other health services that have community-wide benefits. Their children, who are frequently US citizens, may have similar vulnerabilities stemming from their parents' limited engagement with health services. Low-income, non-English-speaking, and farmworker communities have indeed been hot spots for the coronavirus (Fielding-Miller, Sundaram, and Brouwer 2020), while the crowded housing that characterizes many low-income areas is itself a source of infection risk (Emeruwa et al. 2020; Cha 2021).

The federal Coronavirus Aid, Relief, and Economic Security (CARES) Act provided funding to cover the costs of testing and treatment for COVID-19 among the uninsured. But connecting people and communities with medical care—particularly those with less access to health care resources—can still be challenging. And while insurance coverage alone does not guarantee adequate access to care, it clearly reduces the costs of care and should provide a contact point with the health care system.

Under the Affordable Care Act (ACA), California saw dramatic gains in insurance coverage (Cha and McConville 2020). Still, the most current estimate suggests about 3 million Californians did not have comprehensive health insurance coverage in 2019 leading into the pandemic (US Census Bureau 2019). Many of those who continue to lack coverage are undocumented immigrants, who are largely excluded from federally funded public insurance like Medicaid (Lucia 2019). State policymakers have chosen to use state funds to expand eligibility for Medi-Cal, California's Medicaid program, to children and young adults regardless of immigration status, but most undocumented adults are eligible only for emergency services under Medi-Cal.[1]

To help inform policy discussions, we provide a broad overview of the health insurance coverage and medical care available to low-income undocumented immigrants in California. We briefly describe the undocumented and mixed-status population in California and their options for health insurance coverage; we then outline the resources available via the health care safety net, particularly for those who are uninsured. Later, we examine usage patterns and sources of care among immigrant populations. We conclude by discussing the public health implications of such a large group remaining outside the health care system as the state moves forward with vaccination plans to get the economy and society moving again.

[1] Federal law requires hospitals to treat an emergency medical condition, one in which the absence of immediate medical attention could place a patient's health in serious jeopardy, although states have some latitude in determining what constitutes an emergency and the scope of services. Pregnancy-related services constitute a large share of emergency-only Medicaid, although the ACA expansion to single adults without children allows more undocumented adults to be eligible for emergency services.

Undocumented Immigrants in California

More than 2 million California residents are likely undocumented, but there are few reliable sources of information about this group. We use the state-representative California Health Interview Survey (CHIS) because it collects details about immigration status. Immigrants can be naturalized US citizens, permanent residents with green cards, or immigrants without green cards. For brevity, we refer to the latter as undocumented immigrants, with the acknowledgement that this is not strictly accurate (see Technical Appendix D for more on this topic).

In the CHIS, men made up slightly more than half of the undocumented population, the average age was around 38 years old, and the racial groups that made up at least 1 percent of the sample were Asian (12%), Latino (84%), and white (3%) (Technical Appendix Table C1). Over the entire study period, about 61 percent reported some form of health insurance, with Medi-Cal (35%) and employer insurance (24%) the most common types.[2]

The majority of undocumented immigrants in the survey (around 70%) had incomes under 200 percent of the federal poverty level, and this group experienced higher rates of being uninsured than their counterparts with higher incomes (41% versus 35%). Moreover, the low-income group had much lower employer insurance coverage; only 13 percent had employer coverage, compared to 50 percent of higher-income undocumented immigrants. For the remainder of this report, we focus on low-income undocumented immigrants as they are the most likely to face barriers to health coverage and care.

Research design

We use the California Health Interview Survey (CHIS) from 2015 to 2019 to study low-income immigrant adults and children in low-income immigrant families. We focus on adult immigrants with incomes under 200 percent of the federal poverty level (FPL). We estimate the association of various health outcomes with undocumented status, compared to having a green card or US citizenship, while controlling for demographic characteristics, year, and county.

The analyses of children's health outcomes include all children with family incomes under 200 percent of FPL who have an immigrant family member participating in the CHIS. We define children as being from a mixed-status family if any (or all) of their family members participating in the CHIS are undocumented. This underestimates the mixed-status characteristic, and underestimates differences between children in mixed-status families and children in other immigrant families because the latter might also be mixed-status. We model the association of various health outcomes with mixed-status family membership, compared to membership in other immigrant families, while controlling for demographic characteristics, year, and county.

More details are in Technical Appendix B. We discuss selected summary statistics and statistically significant regression findings in this report, but all statistics and regression findings are presented in Technical Appendix C.

[2] As we explain later, many undocumented immigrants reporting Medi-Cal coverage are likely confusing the comprehensive health insurance called Medi-Cal with a restricted version of the program with the same name.

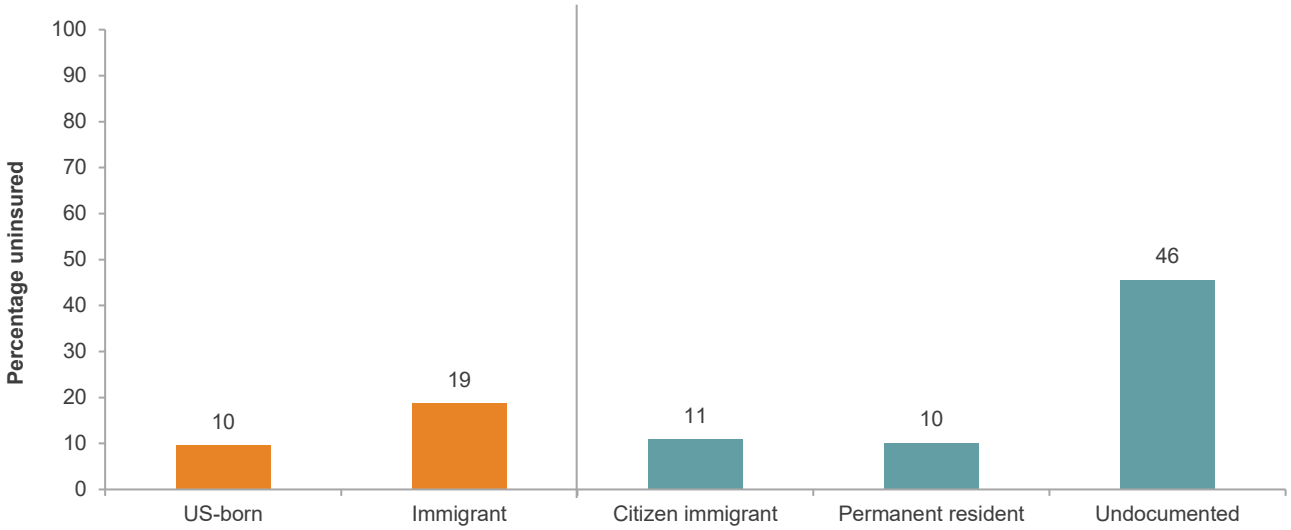
Low-Income Undocumented Immigrants Have High Uninsured Rates

Lack of insurance among immigrants has long been a policy concern (Ku and Matani 2001; Stimpson and Wilson 2018; Derose, Escarce, and Lurie 2007). Immigrants face a range of barriers to coverage, and describing insurance patterns for different groups can help illustrate the types of coverage available. While immigrant adults have higher uninsured rates than US-born adults, immigrants' uninsured rates vary according to their citizenship and permanent residency status (Figure 1). Citizen and permanent resident immigrants have similar uninsured rates to US-born adults, but the undocumented group lacks insurance at a high rate—about 45 percent. In Figure 1, we consider undocumented immigrants to have insurance if they report having Medi-Cal, but they are very likely to be reporting a limited form of Medi-Cal that we describe in the next section. If we remove Medi-Cal as a source of insurance, low-income undocumented immigrants would have an uninsured rate of about 87 percent.

Furthermore, these descriptive details are confirmed in models that control for multiple factors also linked to having insurance—such as demographic characteristics, county, and year. While permanent residents are only about 5 percentage points less likely to have insurance compared to US citizen immigrants, undocumented immigrants are 27 percentage points less likely (see Technical Appendix Table C3). Compared to US citizens, undocumented immigrants are less likely to have all forms of coverage.

FIGURE 1

Low-income undocumented immigrants have much higher uninsured rates compared to other immigrants and US-born Californians



SOURCE: California Health Interview Survey (CHIS) 2019 Adult File.

NOTES: Includes adults age 19 and older under 200 percent of the federal poverty level; a version of these statistics is in Technical Appendix Table C2. Immigrants are foreign-born individuals. In the second panel of the figure, we classify immigrants as citizens, permanent residents (who have green cards), or likely undocumented immigrants (who lack green cards). See Technical Appendix D for more details on immigrants who lack green cards.

Several factors contribute to lower rates of insurance coverage among undocumented immigrants and their families. Eligibility barriers are especially big hurdles. Most undocumented adults are not eligible for

comprehensive coverage from Medi-Cal, the state's Medicaid program (we describe exceptions later), and are not eligible to receive premium subsidies for plans on Covered California, the state's health care marketplace.[3] Undocumented workers are overrepresented in low-skilled jobs that might not offer health insurance (Passel and Cohn 2018). Even compared to US-born workers in low-skilled jobs, though, immigrants are much less likely to have employer health insurance (Buchmueller et al. 2007; Barham, Melo, and Hertz 2020). Among low-income, undocumented adults included in our analysis, about 13 percent have employer coverage (see Technical Appendix Table C2).

For many adults, purchasing an individual plan directly from an insurance company is often prohibitively expensive without assistance. But even if undocumented immigrants wanted to buy unsubsidized insurance through Covered California, federal law bars them from doing so (Covered California 2021).[4] In addition to insurance-specific challenges, fear of deportation may make undocumented immigrants less willing to engage with state agencies. For all of these reasons, undocumented immigrants have lower rates of coverage compared to permanent residents.

Permanent residents have more options. In California, low-income permanent residents can access comprehensive Medi-Cal coverage because the state allows green-card holders to enroll before they meet a federal five-year residency requirement (Fortuny and Chaudry 2014). Covered California has no five-year residency requirement, meaning that permanent residents may purchase insurance and receive federal subsidies through the marketplace. Permanent residents may also be more likely to have better jobs with benefits such as employer-sponsored insurance.

Lack of insurance among undocumented immigrants is especially concerning for older immigrants, who can face mounting health challenges due to aging and past years of uninsured status. Undocumented immigrants over 50, for example, are much less likely to have health insurance compared to immigrants who are permanent residents or citizens (51% vs. 91%) (Technical Appendix Table C13).[5] Part of this difference is due to undocumented immigrants being ineligible for Medicare, which covers upwards of 95 percent of Californians over age 65. However, a state-funded Medi-Cal expansion is now being considered for Californians either over 50 or over 60, regardless of immigration status.

Medi-Cal Coverage for Most Undocumented Adults Is Restricted

Although most undocumented immigrants are excluded from receiving comprehensive benefits under Medi-Cal, they do have access to certain limited services and benefits (Table 1). Undocumented adults may receive emergency services—sometimes referred to as restricted- or limited-scope Medi-Cal—if their incomes do not exceed 138 percent of the federal poverty level (FPL) (or about $17,800 for a single person). Emergency services most often include emergency department (ED) visits, hospital admission if needed, or pregnancy-related services including prenatal care, labor, and delivery.[6]

Emergency Medi-Cal covers treatment of emergent conditions, but also critical needs due to chronic disease, such as emergency dialysis for end-stage kidney disease patients. The state receives federal Medicaid matching funds for emergency services provided to qualified undocumented immigrants. California also receives federal matching

[3] Federal marketplace subsidies have been available to individuals with incomes between 100 and 400 percent of the federal poverty level (FPL) since the beginning of the marketplace, and California state subsidies became available to those with incomes between 0 and 138 percent, and between 200 and 600 percent, of FPL beginning in the 2020 plan coverage year.

[4] A bill in the legislature (AB 570 Santiago) would allow privately insured individuals to cover dependent parents, regardless of immigration status.

[5] In our analysis of CHIS data, we cannot calculate reliable estimates for undocumented immigrants age 65 and older due to small sample sizes.

[6] California also covers breast and cervical cancer treatment under restricted-scope Medi-Cal, and other states like New York provide even broader access to cancer treatments under their restricted-scope Medicaid programs.

funds to cover pregnant and postpartum undocumented immigrants with full-scope care based on the US citizenship of the unborn child (Brooks et al. 2018).

The state operates limited-benefit programs, which provide certain health services to California residents with particular medical needs regardless of immigration status (Belshé and McConville 2013). State limited-benefit programs, also known as "state-only" programs, target specific types of health services (e.g., the Family PACT program provides family planning services) and diseases (e.g., breast cancer screening and treatment is provided through the Every Woman Counts program). In most instances, these programs provide services regardless of immigration status.[7]

TABLE 1

Access to Medi-Cal for undocumented immigrants is limited by age and income

Group	Scope of coverage	Funding source	Income limit (% FPL)	Example of income limit
Children ages 0 to 19th birthday	Full	State*	266	$70,490 for a family of 4
Young adults ages 19 to 26th birthday	Full	State*	138	$17,774 for a single person
Adults ages 26 and older	Restricted	Federal/State	138	$17,774 for a single person
Pregnant and postpartum individuals	Full	Federal/State	322	$56,092 for a family of 2 (including unborn child)

SOURCES: State documents and federal poverty guidelines (California Department of Health Care Services 2020c; US Department of Health and Human Services 2021).

NOTES: Poverty levels are for 2021. Full-scope Medi-Cal is comprehensive public health insurance, whereas restricted-scope Medi-Cal for low-income adults (ages 26+) covers only emergency health services. Some undocumented immigrants may qualify for other forms of restricted-scope Medi-Cal to treat or prevent certain medical conditions. Pregnant women are eligible for full-scope Medi-Cal for 60 days postpartum; after that if they are age 26 or older they would be eligible only for restricted scope and meet the lower income eligibility limit. FPL is federal poverty level. An asterisk (*) indicates that the primary funder is the state, but the federal government contributes some funds that otherwise would have gone toward restricted-scope Medi-Cal for the affected group.

Undocumented immigrants were largely left out of federal health care reform, but some did gain access to restricted-scope Medi-Cal. Prior to the 2010 Affordable Care Act (ACA), low-income undocumented immigrants could qualify for restricted-scope Medi-Cal only if they met categorical eligibility requirements such as having a qualifying disability or dependent children (Sommers 2013). With the expansion of Medi-Cal under the ACA, low-income undocumented immigrants became eligible for restricted-scope Medi-Cal. As of September 2020, more than 850,000 undocumented immigrants were enrolled in restricted-scope Medi-Cal. Nearly 329,000 adults were covered under the ACA expansion category, while another 527,000 were covered under pre-ACA categories, including pregnancy-related services (California Department of Health Care Services 2020a).

Many individuals may not know the difference between restricted-scope and full-scope Medi-Cal since they share the same name. To assess whether this confusion exists among CHIS respondents, we conducted a series of models limited only to low-income immigrants who report having Medi-Cal, and found those with undocumented status are more likely to lack a usual source of care, use a safety net provider as a usual source, and miss health care due to cost (Technical Appendix Tables C7 and C8). Undocumented Californians are less likely to see a doctor or have a routine physical in the past year (Technical Appendix Table C9).These findings together point to

[7]These programs have become considerably smaller in terms of enrollments since the Medi-Cal expansion, as many people who were previously ineligible were able to transition to the Medi-Cal program. Aside from Family PACT, the other state limited-benefit programs are expected to serve about 40,000 Californians in the current fiscal year at a cost of about $330 million—of which $200 million is state funds (California Department of Health Care Services 2020b). California counties also contribute to the financing of some state-only programs.

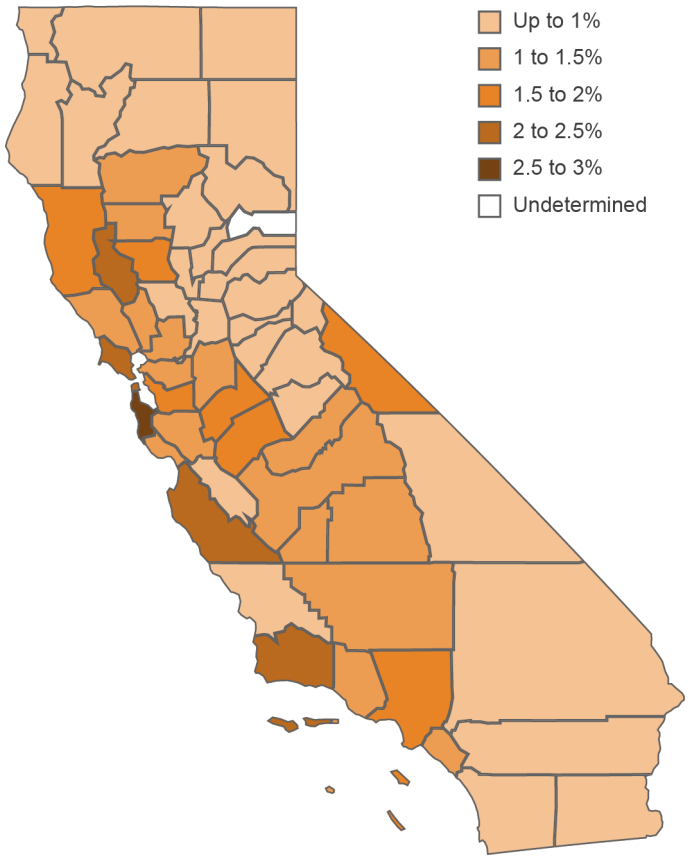
a pattern of low utilization of health care and to financial barriers to care, and are consistent with many undocumented immigrants having access only to restricted-scope Medi-Cal.[8]

Undocumented Children and Young Adults Can Access Full Medi-Cal Benefits

California policymakers have chosen to expand full-scope Medi-Cal to children and young adults regardless of their immigration status if they are income-eligible (Table 1). Under Senate Bill (SB) 75, undocumented children under 19 became eligible for Medi-Cal if their family incomes were below 266 percent of FPL starting in May 2016. The expansion enrolled approximately 120,000 individuals as of June 2020 (California Health and Human Services Agency 2020b). The percentage of affected children differs by county (Figure 2).

FIGURE 2

The percentage of children enrolled in SB 75 Medi-Cal varies greatly by county



SOURCES: California Health and Human Services Open Data and National Cancer Institute Surveillance, Epidemiology, and End Results (SEER) Program County-Level Population File.

NOTES: SB 75 Medi-Cal enrollments in June 2020 shown as a percentage of all children up to age 19 by county as of 2019. Most counties where DHCS (California Department of Health Care Services) suppresses enrollment numbers for confidentiality reasons are assigned to the lowest category (up to 1%) because they would belong there even if they had the largest possible suppressed enrollment; Sierra is the exception, and we do not estimate a percentage for that county.

[8] Some researchers have interpreted Medi-Cal coverage claimed by undocumented immigrants as uninsured status (see, for example, Pourat 2018). There is merit to this interpretation because restricted-scope Medi-Cal is not equivalent to comprehensive health insurance.

Beginning in January 2020, California's SB 104 used primarily state funds to expand full-scope Medi-Cal eligibility to young adults up to age 26, regardless of immigration status, as a follow-up to SB 75. Income eligibility for Medi-Cal is capped at 138 percent of FPL, or about $17,774 for a single adult. (Note that in our CHIS study data, SB 104 had not yet been implemented, so young adults age 19 to 26 were ineligible for full-scope Medi-Cal.)

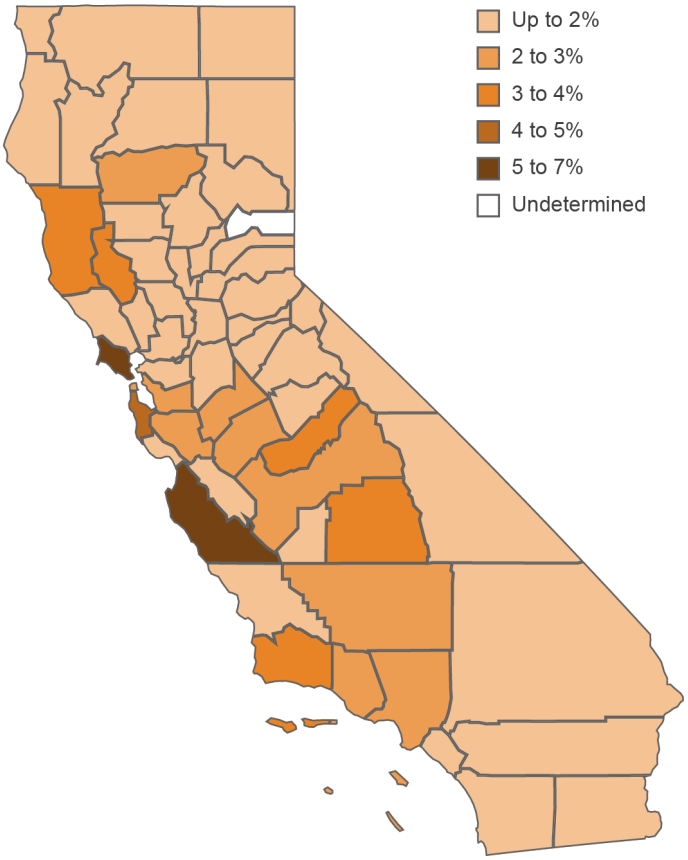
The program enrolled about 78,000 young adults as of June 2020, which is a smaller number than the child expansion, but the affected percentages vary by county and can be substantially higher in some, such as Marin and Monterey (California Health and Human Services Agency 2020a), where the covered population of young adults exceeds 5 percent (Figure 3).

State general funds pay for the majority of costs for these expansions. The 2020–21 budget projected total costs for young adults of $265 million, of which $183 million came from the General Fund (California Department of Health Care Services 2020b). The expansion to undocumented children costs about $300 million annually (Brown 2017).

Beyond children and young adults, other undocumented immigrants who have a range of temporary immigration statuses are eligible for full-scope Medi-Cal; this includes participants in the federal Deferred Action for Child Arrivals (DACA) program (see Technical Appendix D). Official state guidance directs counties to provide coverage to certain groups of undocumented immigrants, but the rules are complex and local implementation could vary (California Department of Health Care Services 2017).

FIGURE 3

Young adult enrollments in Medi-Cal under the SB 104 expansion had deep reach in Marin and Monterey Counties



SOURCES: California Health and Human Services Open Data and National Cancer Institute Surveillance, Epidemiology, and End Results (SEER) Program County-Level Population File.

NOTES: SB 104 Medi-Cal enrollments in June 2020 shown as a percentage of all young adults ages 19–25 by county as of 2019. Most counties where DHCS suppressed enrollment numbers for confidentiality reasons are assigned to the lowest category (up to 2%) because they would belong there even if they had the largest possible suppressed enrollment; Sierra is the exception, and we do not estimate a percentage for that county.

The governor's proposed expansion to low-income undocumented immigrants age 60 and older would cover far fewer people than the child and young adult expansions, but would cost considerably more due to the greater health needs of older populations.[9] The May Revision of the governor's budget estimates ongoing annual costs of about $1 billion for this expansion, of which $859 million would be from state General Funds (Newsom 2021).[10] The legislature prefers the expansion to cover adults age 50 and older, which would bring the estimated annual costs up to $1.3 billion (Ting and Skinner 2021). Expanding full-scope Medi-Cal to all low-income undocumented adults over age 26 would result in even higher ongoing costs, likely in the range of $2 billion to $3 billion (Johnson 2021; Newsom 2021).

[9] Although their numbers are smaller, better understanding the health needs of older undocumented immigrants can help with planning for the Medi-Cal expansion to this group.

[10] Past studies found that the estimated number of undocumented seniors ages 65 and older was around 25,000 (Lucia 2019) or 29,000 (Petek 2020); note the most recent proposal in the May 2021 budget also includes seniors ages 60–64.

Federal Immigration Actions Have Deterred Immigrants from Accessing Public Programs

Federal concerns over immigration were heightened during the Trump administration, and this may have led fewer undocumented immigrants and their family members to access health care. Regardless of the presidential administration, deportation is an ongoing fear for many undocumented immigrants. California became a sanctuary state in 2017 under SB 54, which limited cooperation between local law enforcement and federal immigration enforcement, but this has not abated the perceived threat of deportation (KQED Public Radio 2020).

Undocumented immigrants may also worry that using public programs could hurt their chances of eventually getting a green card. The Trump administration updated a federal public-charge rule, making participation in safety net programs a stronger factor against immigrants' entry and green card applications. The rule change was highly technical, did not apply to most cases, and was blocked multiple times by courts. However, it bred alarm and confusion in immigrant communities. During the 2020 recession, immigrant families across the nation avoided programs like Medicaid and the Supplemental Nutrition Assistance Program (formerly food stamps) due to immigration concerns, including the public-charge rule, with the highest rates of avoidance among families with at least one nonpermanent resident (Bernstein et al. 2021). In California, a quarter of low-income permanent residents reported avoiding public programs due to concerns about their immigration status, even though the rule change did not apply to them (Babey et al. 2021).

The Biden administration has dropped the previous presidential administration's efforts to overcome legal challenges to the new public-charge rule. But lingering fears may have repercussions for immigrants' citizen children or other household members eligible for public programs who are concerned about applying.

Currently, the Biden administration is proposing comprehensive reform of immigration policy, with paths to citizenship for undocumented immigrants and fast-tracked possibilities for some groups, including DACA recipients and farmworkers. Still, it would take years for current undocumented immigrants to become citizens, and their health coverage and care would remain unresolved in the interim without additional actions.

Undocumented Immigrants Have Weaker Connections to Health Care

Because of their low rates of health insurance coverage, many undocumented immigrants must rely on health care safety net resources, such as public hospitals or community clinics, to access needed medical care. Despite serving as important access points, none of these resources is equivalent to having comprehensive health insurance coverage.

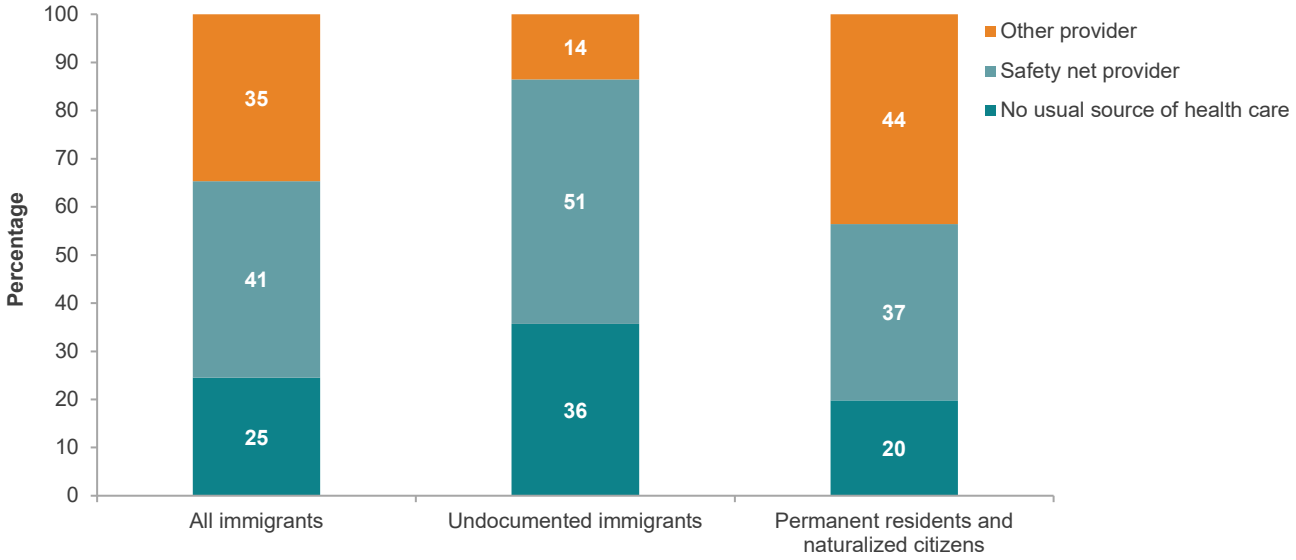
Health Care Safety Net Providers

The state's large network of health care clinics is a key component of the safety net and a major source of primary care—including preventive, dental, and behavioral health—for undocumented immigrants. Federally qualified health centers, free clinics, and rural health clinics all provide a crucial access point to undocumented immigrants, with most clinics located in communities where undocumented residents live (Lee, Hill, and McConville 2012). County hospital systems—in the 12 large counties that have them—also operate health clinics and provide access to specialty and inpatient hospital care for many uninsured and Medi-Cal patients, including undocumented immigrants (Kelch 2015). All of these safety net providers offer care on a sliding-scale based on patient income levels and serve patients regardless of immigration status. Finally, hospital emergency departments (EDs) serve as a critical access point to health care for uninsured, undocumented residents due to federal regulations requiring EDs to provide medically necessary care to all patients.

A key marker that individuals have access to health care is when they have a trusted and consistent connection to the health care system; this connection is also associated with better health outcomes, fewer disparities, and lower costs (Office of Disease Prevention and Health Promotion 2021). Among all low-income immigrants, about a quarter reported they did not have a usual place they received health care, and over 40 percent reported safety net providers as their usual source of care (Figure 4 and Technical Appendix Table C2). Undocumented immigrants were even less likely to have a regular contact point to receive health care. In models controlling for factors like age and county of residence, undocumented adults were 11 percentage points less likely to have a usual source of health care and nearly 7 percentage points more likely to identify a safety net provider as their usual source compared to other low-income immigrants (Technical Appendix Table C4).

FIGURE 4

More than half of low-income undocumented immigrants report a safety net provider as their usual source of care



SOURCE: California Health Interview Survey 2015–2019 adult files.

NOTES: Includes immigrants ages 19 and older under 200 percent of the federal poverty level; the featured information and related statistics on usual source of care are available in Technical Appendix Table C2. Safety net providers include community clinics, public hospitals, and emergency departments. Numbers may not add to 100 due to rounding.

County Indigent Programs

Under California law, counties are tasked with providing health care to medically indigent residents—Californians without financial means or health insurance coverage. Counties meet this requirement by operating county indigent care programs. Some large counties operate public hospital systems to provide health care to their indigent residents, while others contract with health plans and select providers to meet their indigent care responsibilities. Counties do receive some state funds to support their health programs, but state financing of county indigent care has changed in recent years.[11]

Counties have considerable flexibility in the design of their indigent care programs in terms of eligibility requirements, covered medical services, and costs to participants (Insure the Uninsured Project 2019). Counties are not required to cover medical services provided to undocumented indigent residents, although most do. Currently, 47 California counties provide indigent care services to residents regardless of immigration status, though other eligibility requirements such as qualifying income levels may make some ineligible (Insure the Uninsured Project 2019).[12]

In past work, we estimated that about a third of undocumented immigrants live in regions where they are not eligible for their county indigent program due to immigration status (McConville et al. 2015); the proportion is similar in our current analysis (Technical Appendix Table C2). When study members lived in counties that serve undocumented immigrants in their indigent programs, it did not influence where they went for their usual source of health care, whether they missed health care or prescriptions due to cost, the likelihood of visiting an ED, or the

[11] When state officials decided to expand the Medi-Cal program under the ACA, funding for county indigent care programs was reduced because many of the people served by these programs would become eligible for Medi-Cal.

[12] The eleven counties that do not provide services to undocumented immigrants through their county indigent care programs include Merced, Orange, Placer, San Bernardino, San Diego, San Joaquin, San Luis Obispo, Santa Barbara, Stanislaus, and Tulare (Insure the Uninsured Project 2019).

likelihood of seeking preventive care (Technical Appendix Tables C10–C12).[13] While counties are health care providers of last resort, their medically indigent care policies do not appear to drive health care outcomes for undocumented immigrants more broadly.

My Health LA

Los Angeles County is home to between 800,000 and 900,000 undocumented immigrants, suggesting that close to half of California's undocumented residents live there. My Health LA is one of the county's indigent care programs and serves Los Angeles residents who are eligible for Medi-Cal based on their income (under 138% of FPL) but do not qualify because of their immigration status—so all enrollees are likely to be undocumented. As of January 2021, nearly 125,000 adults were enrolled in My Health LA and assigned to a community clinic that serves as their medical contact point (Los Angeles County Health Services 2021). No children or young adults participate because they are eligible for full-scope Medi-Cal, and an individual must apply for Medi-Cal before enrolling in My Health LA.

Detailed information on enrollee characteristics, health care usage, and program costs can provide valuable insights about the health needs of the undocumented population in the state. In 2018–19, My Health LA served about 180,000 unique participants over the course of the fiscal year, with an average monthly enrollment of about 145,000 (Los Angeles County Health Services 2019). This suggests nearly one in five undocumented residents in Los Angeles County were connected to the program, which provides primary care including prescriptions and dental care through a network of community clinics as well as specialty and inpatient care, mainly from the county's public hospital system.

Again, none of these safety net resources, including My Health LA, is equivalent to having comprehensive health coverage, despite providing access to primary, specialty, and inpatient hospital care. Individuals covered under indigent care programs—including undocumented immigrants—can only receive medical services within the county in which they are enrolled. And while safety net providers like clinics and hospital emergency departments are accessible nationwide, the medical services available through these providers are limited.

Undocumented Adults Use Less Health Care, Limiting Insights into their Health Status

Data on health care expenditures for undocumented immigrants are difficult to come by, but existing studies show that undocumented immigrants use and spend less on health care compared to other groups. An older study of health care expenditures in California found that undocumented immigrants use less health care than other immigrant groups (permanent residents and naturalized citizens) and the US-born (Goldman, Smith, and Sood 2006). National work—using pre-ACA data—found that health care spending from public sources went to a far smaller proportion of undocumented immigrants (8%) compared to US-born individuals (30%). Higher shares of undocumented immigrants receive uncompensated care (5.9%) compared to permanent residents (4.7%), naturalized citizens (2.3%), and US-born individuals (2.8%) (Stimpson, Wilson, and Su 2013). However, far more undocumented immigrants use no health care (40%) compared to permanent residents (28%), naturalized citizens

[13] Analyses comparing Los Angeles or San Francisco Counties, which have robust integrated health systems serving undocumented immigrants, with other counties serving undocumented immigrants or counties not serving undocumented immigrants at all found no significant differences associated with living in different types of counties on a range of access-to-care measures.

(17%), and the US-born (13%) (Stimpson, Wilson, and Su 2013). And more recent community-based studies in California found that undocumented immigrants try to stay healthy and often avoid seeing a doctor due to fears that we discuss below (Plascencia et al. 2014).

These studies cover the period before national health reform. Since the provisions of the ACA generally do not apply to undocumented immigrants, undocumented immigrants' engagement with the health care system is likely staying the same or even decreasing, while permanent residents and citizens are getting better coverage and care, further widening the gap between undocumented immigrants and other Californians.

In recent years, health care access among undocumented immigrants may have decreased due to the charged political climate surrounding immigrants. After the 2016 presidential campaign, which featured anti-immigrant rhetoric by candidate—and later President—Trump, undocumented immigrants' use of primary care declined relative to other low-income immigrants (Nwadiuko et al. 2021). There is also heterogeneity among immigrants; for example, there are reported differences in health care access within and across Latino national origin groups (Bustamante et al. 2018; Vargas Bustamante et al. 2012).

We focus on comparing undocumented immigrants to permanent residents and citizen immigrants, and find that undocumented immigrants are not more likely than other immigrants to report missing health care or picking up a prescription medication, but they are more likely to miss health care due to cost or insurance-related reasons (Technical Appendix Table C4). Despite concerns that undocumented immigrants may turn to EDs because they lack other sources of care, only a small percentage (under 3%) of low-income immigrants—including those that are undocumented—report the ED as their usual source of care (Technical Appendix Table C4).

When we analyze having any ED visit in the past year, the number of ED visits, or the likelihood of having at least two ED visits, undocumented immigrants did not use EDs at higher rates than other low-income immigrant groups (Technical Appendix Table C6). Other components of the health care safety net—community clinics and public hospitals—play a bigger role for immigrants, with nearly half of undocumented immigrants reporting these venues as their usual sources of care.

Children in mixed-status families who have a usual source of care tend to see the same types of providers as children in other immigrant families. These children are no more likely to report the ED, a clinic or public hospital, or safety net providers in general as their usual source of care. As with immigrant adults, nearly half of children in mixed-status immigrant families report safety net providers as their usual source (Technical Appendix Table C18).

Low Health Care Use Could Be a Factor in Self-Reported Health Status

Underlying health status may drive some of the differences in how individuals use health care resources; unfortunately, there is little information on health status for undocumented immigrant adults. On one hand, they tend to be younger and employed, suggesting they may be a healthier group overall. Their ability to migrate to the US also may signal that undocumented adults are healthier than other groups. On the other hand, they have much less access to employer-based health coverage, despite often working difficult jobs that may carry higher health risks, such as farm work and construction.

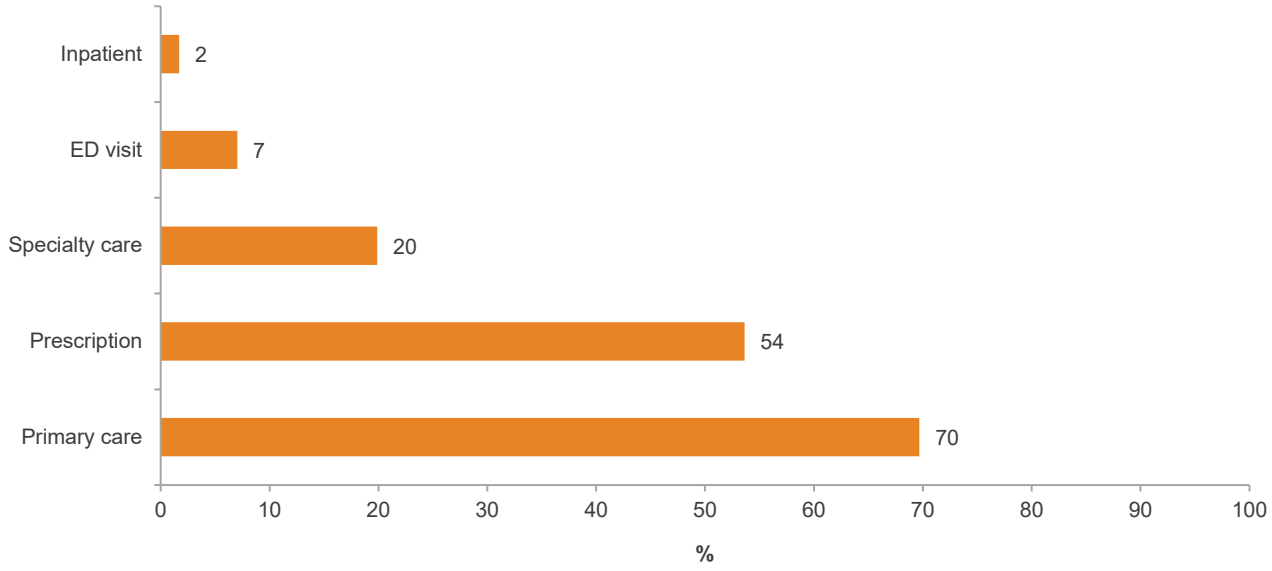
Undocumented immigrants rate their own health similarly to other immigrants in California, with about 11 percent reporting "excellent" health and about a third reporting "poor" or "fair" health (Technical Appendix Table C2). While their diagnosed rates of asthma, diabetes, and heart disease are lower than for other immigrants, perhaps because they interact less with the health care system, underlying rates could be quite different from what individuals can accurately report about themselves. One condition that can be identified outside of a doctor's

office is unhealthy body weight. Undocumented immigrants have slightly higher rates of being overweight (72% vs. 68%) or obese (35% vs. 32%) compared to other immigrants (Technical Appendix Table C2).[14]

Presumably, undocumented immigrants with chronic conditions and greater health care needs would be most likely to enroll in a county indigent program to receive needed medical care. Indeed, about 45 percent of My Health LA enrollees have a chronic condition—the top three of which are diabetes, hypertension, and high cholesterol (Los Angeles County Health Services 2019). Few received inpatient hospital care (2%) or visited an ED (7%) at some point during the year (Figure 5). But seven in ten enrollees went to primary care at least once, and more than half filled prescriptions. Diabetes-related prescriptions represented nearly 25 percent of total prescriptions, while medications for high blood pressure and high cholesterol represented 17 percent (Los Angeles County Health Services 2019). However, we do not know to what extent My Health LA enrollees are representative of undocumented immigrants in terms of their health and health care needs.

FIGURE 5

Few undocumented immigrants in MyHealth LA use hospital inpatient or emergency department services



SOURCE: Los Angeles County Department of Health, MyHealth LA Annual Report 2018–19 (Los Angeles County Health Services 2019).

NOTE: Includes 181,902 unique participants who were enrolled in MyHealth LA for at least one month in fiscal year 2018–19. Percentages reflect the share of enrollees who had at least one of the types of health services listed during the year.

Older Undocumented Immigrants Could Have Significant Health Needs

If undocumented immigrants continue without health coverage and care over their working years, even greater health needs may arise as they age. The undocumented immigrant population is concentrated among working-age adults (rather than children or the elderly), and in our data, their population becomes quite sparse at older ages. We focus on immigrants age 50 and older to gain insight on potential health issues. Compared to other immigrants 50 and older, undocumented immigrants are less likely to have seen a doctor for any reason in the past year (70% vs. 82%) or for a routine exam (56% vs. 78%) (Technical Appendix Table C13).[15]

[14] We use the body mass index (BMI) values provided by the CHIS. BMI is calculated as weight (lb) / [height (in)]^2 x 703 (Centers for Disease Control and Prevention 2021). We use the conventional thresholds of BMI >= 25 for overweight and BMI >=30 for obesity.

[15] These are unadjusted summary statistics.

Despite receiving less care, older undocumented immigrants rate their own health similarly to other immigrants their age. They also report possibly lower rates of diagnosed asthma (6% vs. 10%), diabetes (25% vs. 32%), and heart disease (8% vs. 13%) compared to other immigrants, but as with younger undocumented immigrants, this could very well be due to lack of health care access.[16] In terms of health conditions that can be determined without diagnoses, older undocumented immigrants have higher rates of being overweight (78% vs. 67%) or obese (36% vs. 31%) compared to other immigrants. With higher body weight, these individuals may face greater health challenges as they age, though accurate health status is difficult to gauge using survey data.

When we control for age, other demographics, and factors like county of residence, we do not see significant differences between undocumented immigrants and other immigrants on self-reported health, having specific diagnosed conditions, or being overweight/obese (Technical Appendix Table C16).

Children in Mixed-Status Families Receive Needed Care despite Obstacles

Among children in immigrant families, the proportion who are undocumented is relatively small—over 94 percent are US citizens in our study sample from the CHIS. Although all low-income children in California have access to Medi-Cal regardless of immigration status, when family members are undocumented, it may influence how children engage with safety net programs and the health care system. Even when we control for a range of factors, children in mixed-status families are more than 9 percentage points less likely to have a usual source of health care compared to children in other immigrant families (Technical Appendix Table C18).

When children have a usual source of health care, it is a better measure of their access to care than insurance coverage, and correlates with whether their parents have a usual source—an important consideration in mixed-status families (DeVoe et al. 2012; DeVoe et al. 2011). While our analyses likely underestimate the effect of being in a mixed-status family, they should still be interpreted with caution (see Technical Appendix B). However, the results suggest that undocumented family members either fear engaging with the health care system, or that children are less likely to get consistent health care when their parents do not also see the doctor regularly.

Although children in mixed-status families are less likely to have a usual source of care, they are no more likely to miss a health care visit or filling a prescription medication than children in other immigrant families; though the lack of findings could be due to poor measurement of the mixed-status characteristic (Technical Appendix Table C19). Among those who did miss care or medication, cost was no more likely to deter children in mixed-status families.

There were also no differences in ED use or preventive care associated with being from a mixed-status family (Technical Appendix Table C20)—children in mixed-status families were about as likely as others to visit an ED, see a doctor, get a routine exam, or see a dentist in the past year. They also received preventive care at relatively high rates, with more than 90 percent receiving a routine medical exam and about 85 percent seeing a dentist (Technical Appendix Table C17). Better access among children compared to adults is likely because of the low proportion of undocumented status among children, combined with the state providing universal access for all low-income children in Medi-Cal beginning in 2016.

[16] Selected statistics on older adults' health are presented by five-year age bands in Technical Appendix Table C13 and Table C14, but the sample sizes (especially in the undocumented group in Table C13) are quite small and readers should view the tables with caution.

Moving Forward from the Public Health Crisis

Since the Great Recession, the undocumented population has been declining, though California continues to be a state with a high share of the nation's total (Krogstad, Passel, and Cohn 2019). Thinking beyond the current pandemic, California policymakers are once again considering coverage expansions to residents regardless of immigration status. There are legislative efforts around Medi-Cal expansion to all undocumented adults, and the Healthy California for All state commission is studying options for achieving universal health care coverage through a state-based financing system.

If lawmakers seek to increase coverage, private insurance has a role to play as well. As we described, most low-income undocumented immigrants have little access to private coverage due to a combination of affordability, jobs that do not offer insurance, and federal exclusions. Targeted policy changes could reduce these barriers. AB 570 (Santiago) is proposing to let privately insured individuals cover their dependent parents, including those who are undocumented. In 2016, the state legislature authorized a federal waiver request that would have allowed undocumented immigrants to purchase insurance through Covered California (California Legislative Information 2016). However, the waiver request was not submitted due to the negative political climate surrounding immigrants after Donald Trump's election to the presidency. The current federal climate may be open to it. Opening Covered California to undocumented immigrants could provide additional coverage options, though state subsidies akin to the federal premium subsidies may be needed to support low- and moderate-income purchasers. California introduced first-in-nation state subsidies up to 600 percent of FPL (McConville 2021), so this policy tool does have precedent.

A number of California legislators continue to pursue policy proposals that would expand coverage options to all California residents regardless of immigration status, but funding is a big challenge. Legislators recently tabled a universal care bill (Assembly Bill 1400 Kalra) in order to develop a realistic funding plan.

Independent of coverage expansions, state policymakers could incentivize counties financially to provide care to undocumented immigrants in their programs for the medically indigent, while also targeting additional resources to safety net providers such as clinics, public hospitals, and emergency departments. Regardless of the approach, outreach to immigrants and their family members through community-based organizations and other trusted messengers will be essential to reduce recent fears that arose around government programs.

Finally, state efforts could be balanced by developments at the federal level. The Biden administration initially signaled interest in pursuing comprehensive immigration reform with pathways to citizenship for undocumented immigrants, though recent proposals have become more narrow in scope. If federal reforms succeed in providing more people with a pathway to legal residency, undocumented health coverage could become a smaller budget commitment for California.

The COVID-19 crisis has illustrated how the vulnerability of some groups can lead to health risks for others. One particular group of concern is children in mixed-status families. In spite of frequently being US citizens, they may have less access to health care for reasons associated with the immigration status of family members. Improving access to health insurance and making safety net health care more than a patchwork promises to improve the clinical health of undocumented immigrants and their family members, as well as the public health of the state.

REFERENCES

Babey, Susan H., Joelle Wolstein, Riti Shimkhada, and Ninez A. Ponce. 2021. "One in 4 Low-Income Immigrant Adults in California Avoided Public Programs, Likely Worsening Food Insecurity and Access to Health Care." Health Policy Brief. UCLA Center for Health Policy Research.

Baldassare, Mark, Dean Bonner, Rachel Lawler, and Deja Thomas. 2021. *PPIC Statewide Survey: Californians and Their Government* (March). Public Policy Institute of California.

Barham, Bradford L., Ana P. Melo, and Thomas Hertz. 2020. "Earnings, Wages, and Poverty Outcomes of US Farm and Low-Skill Workers." *Applied Economic Perspectives and Policy* 42 (2): 307–34.

Belshé, Kim, and Shannon McConville. 2013. "Rethinking the State-Local Relationship: Health Care." Public Policy Institute of California.

Bernstein, Hamutal, Michael Karpman, Dulce Gonzalez, and Stephen Zuckerman. 2021. "Immigrant Families Continued Avoiding the Safety Net during the COVID-19 Crisis." Urban Institute.

Brooks, Tricia, Karina Wagnerman, Samantha Artiga, and Elizabeth Cornachione. 2018. "Mediciad and CHIP Eligibility, Enrollment, Renewal, and Cost Sharing Policies as of January 2018: Findings from a 50-State Survey." Kaiser Family Foundation.

Brown, Edmund G. 2017. "2017–18 Governor's Budget Summary." Governor of the State of California.

Buchmueller, Thomas C., Anthony T. Lo Sasso, Ithai Lurie, and Sarah Dolfin. 2007. "Immigrants and Employer-Sponsored Health Insurance." *Health Services Research* 42 (1p1): 286–310.

Bustamante, Arturo Vargas, Ryan M. McKenna, Joseph Viana, Alexander N. Ortega, and Jie Chen. 2018. "Access-to-Care Differences between Mexican-Heritage and Other Latinos in California after the Affordable Care Act." *Health Affairs* 37 (9): 1400–1408.

California Department of Health Care Services. 2017. "Statement of Citizenship, Alienage, and Immigration Status Form (MC13)."

California Department of Health Care Services. 2020a. "Medi-Cal Monthly Eligible Fast Facts: Characteristics of the Medi-Cal Population as Captured by the Medi-Cal Eligibility Data System (MEDS)."

California Department of Health Care Services. 2020b. "Family Health November 2020 Local Assistance Estimate for Fiscal Years 2020–21 and 2021–22." November.

California Department of Health Care Services. 2020c. "Short-Doyle Medi-Cal (SMDC) Aid Code Master Chart."

California Health and Human Services Agency. 2020a. "Eligible Young Adult Expansion Individuals Enrolled in Medi-Cal—California Health and Human Services Open Data Portal." 2020.

California Health and Human Services Agency. 2020b. "SB 75—Full Scope Medi-Cal for All Children Enrollment."

California Legislative Information. 2016. "SB-10 Immigration Status." June 10.

Capps, Randy, Julia Gelatt, Ariel G. Ruiz Soto, and Jennifer Van Hook. 2020. "Unauthorized Immigrants in the United States: Stable Numbers, Changing Origins." Fact Sheet. Migration Policy Institute.

Centers for Disease Control and Prevention. 2021. "Calculating BMI Using the English System—BMI for Age Training Course—DNPAO."

Cha, Paulette. 2021. "Immigrants and Health in California." Just the Facts. Public Policy Institute of California.

Cha, Paulette, and Shannon McConville. 2020. "California's Future: Health Care." Public Policy Institute of California.

Covered California. 2021. "Information for Immigrants—Covered California."

Derose, Kathryn Pitkin, José J. Escarce, and Nicole Lurie. 2007. "Immigrants and Health Care: Sources of Vulnerability." *Health Affairs* 26 (5): 1258–68.

DeVoe, Jennifer E., Carrie J. Tillotson, Lorraine S. Wallace, Heather Angier, Matthew J. Carlson, and Rachel Gold. 2011. "Parent and Child Usual Source of Care and Children's Receipt of Health Care Services." *The Annals of Family Medicine* 9 (6): 504–13.

DeVoe, Jennifer E., Carrie J. Tillotson, Lorraine S. Wallace, Sarah E. Lesko, and Nancy Pandhi. 2012. "Is Health Insurance Enough? A Usual Source of Care May Be More Important to Ensure a Child Receives Preventive Health Counseling." *Maternal and Child Health Journal* 16 (2): 306–15.

Emeruwa, Ukachi N., Samsiya Ona, Jeffrey L. Shaman, Amy Turitz, Jason D. Wright, Cynthia Gyamfi-Bannerman, and Alexander Melamed. 2020. "Associations between Built Environment, Neighborhood Socioeconomic Status, and SARS-CoV-2 Infection among Pregnant Women in New York City." *JAMA* 324 (4): 390.

Fielding-Miller, Rebecca K., Maria E. Sundaram, and Kimberly Brouwer. 2020. "Social Determinants of COVID-19 Mortality at the County Level." Edited by Nickolas D. Zaller. *PLOS ONE* 15 (10): e0240151.

Fortuny, Karina, and Ajay Chaudry. 2014. *Overview of Immigrants' Eligibility for SNAP, TANF, Medicaid, and CHIP*. Urban Institute.

Goldman, Dana P., James P. Smith, and Neeraj Sood. 2006. "Immigrants and the Cost of Medical Care." *Health Affairs* 25 (6): 1700–1711.

Immigrant Legal Resource Center. 2020. "Medi-Cal in California: Addressing Community Concerns about Public Charge." Immigrant Legal Resource Center.

Insure the Uninsured Project. 2019. "County Medically Indigent Programs."

Johnson, Ben. 2021. "Estimated Cost of Expanding Full-Scope Medi-Cal Coverage to All Otherwise-Eligible Californians Regardless of Immigration Status." Legislative Analyst's Office, May 5, 2021.

Kelch, Deborah. 2015. "Locally Sourced: The Crucial Role of Counties in the Health of Californians." California Health Care Foundation.

KQED Public Radio. 2020. "State Lawmakers Urge Newsom to Stop Transferring People in Prison to ICE in Pandemic—KQED." July 6.

Krogstad, Jens Manuel, Jeffrey S. Passel, and D'Vera Cohn. 2019. "5 Facts about Illegal Immigration in the US." *Pew Research Center* (blog). June 12.

Ku, L., and S. Matani. 2001. "Left Out: Immigrants' Access to Health Care and Insurance." *Health Affairs* 20 (1): 247–56.

Lee, Helen, Laura Hill, and Shannon McConville. 2012. "Access to the Health Care Safety Net in California." Public Policy Institute of California.

Los Angeles County Health Services. 2019. "My Health LA: Annual Report to the Los Angeles County Board of Supervisors Fiscal Year 2018—19."

Los Angeles County Health Services. 2021. "My Health LA Program: Key Demographics and Enrollment Summary."

Lucia, Laurel. 2019. "Towards Universal Health Coverage: Expanding Medi-Cal to Low-Income Undocumented Adults." UC Berkeley Labor Center.

McConville, Shannon. 2021. "Health Care Reform in California." Just the Facts. Public Policy Institute of California.

McConville, Shannon, Laura Hill, Iwunze Ugo, and Joseph Hayes. 2015. *Health Coverage and Care for Undocumented Immigrants*. Public Policy Institute of California.

Newsom, Gavin. 2021. "May Revision 2021–22." California Department of Finance.

Nwadiuko, Joseph, Jashalynn German, Kavita Chapla, Frances Wang, Maya Venkataramani, Dhananjay Vaidya, and Sarah Polk. 2021. "Changes in Health Care Use among Undocumented Patients, 2014–2018." *JAMA Network Open* 4 (3): e210763.

Office of Disease Prevention and Health Promotion. 2021. "Access to Health Services—Healthy People 2020."

Passel, Jeffrey S., and D'Vera Cohn. 2018. "US Unauthorized Immigrant Total Dips to Lowest Level in a Decade" Pew Research Center: Hispanic Trends, November.

Petek, Gabriel. 2020. "Analysis of the Medi-Cal Budget." Sacramento, CA: Legislative Analyst's Office.

Plascencia, Imelda S., Alma Leyva, Mayra Yoana, Jaimes Pena, and Saba Waheed. 2014. "Part 1: No Papers, No Health Care." *Undocumented and Uninsured: A Five-Part Report on Immigrant Youth and the Struggle to Access Health Care in California*. UCLA Labor Center.

Pourat, Nadereh. 2018. "Six Facts about Undocumented Californians: Analysis of the 2015–2016 California Health Interview Survey." Slide deck presented at the California Health Care Foundation, June 6.

Sommers, Benjamin D. 2013. "Stuck between Health and Immigration Reform—Care for Undocumented Immigrants." *New England Journal of Medicine* 369 (7): 593–95.

Stimpson, Jim P., and Fernando A. Wilson. 2018. "Medicaid Expansion Improved Health Insurance Coverage For Immigrants, but Disparities Persist." *Health Affairs* 37 (10): 1656–62.

Stimpson, Jim P., Fernando A. Wilson, and Dejun Su. 2013. "Unauthorized Immigrants Spend Less than Other Immigrants and US Natives on Health Care." *Health Affairs* 32 (7): 1313–18.

Taylor, Mac. 2016. "Analysis of the Medi-Cal Budget." Legislative Analyst's Office.

Ting, Phil, and Nancy Skinner. 2021. "The 2020-21 State Budget: Legislature's Version."

US Census Bureau. 2019. "American Community Survey Tables for Health Insurance Coverage." The United States Census Bureau. 2019.

US Department of Health and Human Services. 2021. "2021 Poverty Guidelines." Office of the Assistant Secretary for Planning and Evaluation (ASPE). January 26.

Van Hook, Jennifer, James D. Bachmeier, Donna L. Coffman, and Ofer Harel. 2015. "Can We Spin Straw into Gold? An Evaluation of Immigrant Legal Status Imputation Approaches." *Demography* 52 (1): 329–54.

Vargas Bustamante, Arturo, Hai Fang, Jeremiah Garza, Olivia Carter-Pokras, Steven P. Wallace, John A. Rizzo, and Alexander N. Ortega. 2012. "Variations in Healthcare Access and Utilization among Mexican Immigrants: The Role of Documentation Status." *Journal of Immigrant and Minority Health* 14 (1): 146–55.

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