PUBLIC CHARGE

Reducing the Chilling Effects on Medi-Cal Participation Due to the 2018 Proposed Public Charge Rule

Grace Kim • Renee Lahey • Marcus Silva • Sean Tan

2019

UCLA Luskin School of Public Affairs

CALIFORNIA IMMIGRANT POLICY CENTER

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DISCLAIMER

Information in this report was derived from a full-length Applied Policy Project (APP) study prepared in partial fulfillment of the requirements for the Master of Public Policy degree in the Department of Public Policy at the University of California, Los Angeles. It was prepared at the direction of the Department and the California Immigrant Policy Center as a policy client. The views expressed herein are those of the authors and not necessarily those of the Department, the UCLA Luskin School of Public Affairs, UCLA as a whole, or the client.

EXECUTIVE SUMMARY

On October 10, 2018, the U.S. Department of Homeland Security (DHS) formally proposed the first major change to the "public charge" rule since 1996, drastically broadening the grounds on which an immigrant could be denied legal permanent residency or admission to the United States. On August 14th DHS published the final language of the expanded public charge rule. Pending the outcome of litigation, the rule will go into effect on October 15, 2019. The proposed rule broadens the definition of public charge to include immigrants who use one or more government programs, expands the list of public benefits previously considered and adds specific requirements to the public charge test for income, health, age and even English proficiency.

The anti-immigrant rhetoric from the Administration coupled with policy change proposals have created fear and confusion within immigrant communities and families are disenrolling from fear of immigration related consequences. In 2018, one in seven immigrants disenrolled from key safety net programs. Known as *the chilling effect, or* "not applying for or stopping participation... because of concerns that [one]...could be disqualified from obtaining a green card," families are rapidly disenrolling from programs. The proposed rule change led to a partnership between the California Immigrant Policy Center and the UCLA Luskin School of Public Affairs on policy changes that could reduce the impact of public charge on MediCal, in particular. The three policy solutions explored in the full report include:

1. **Express Lane Eligibility (ELE)**, which would use enrollment in other means-tested public benefits programs to verify eligibility and automatically enroll and renew beneficiaries in Medi-Cal.

2. A **Naturalization Campaign** that would notify people of their eligibility for application fee waivers plus education and legal support.

3. **Real-Time Eligibility Determination (RTED)** to simplify and automate Medi-Cal enrollments and renewals.

In this brief, we identify and evaluate possible ways to counteract the adverse chilling effects created by public charge by maximizing Medi-Cal participation among California's chilled population.

INTRODUCTION
"PUBLIC CHARGE" AND THE PROPOSED RULE CHANGE

The Department of Homeland Security (DHS) proposed changes to the "public charge" rule is expected to curb immigration dramatically and harm immigrant families.[1] Although immigrants have been denied entry to the United States on the basis of public charge determinations since 1882, the Illegal Immigration Reform and Immigrant Responsibility Act (IIRIRA) last updated the definition of a public charge in 1996 to an individual "primarily dependent on the government for subsistence, as demonstrated by the receipt of cash assistance... or institutionalization for long-term care at government expense."[2]

Since then, immigrants deemed to be a "public charge" or likely to become a "public charge" have been rejected on these grounds: when (1) applying for entry to the United States, (2) requesting adjustment of status to legal permanent residency (i.e., applying for a "green card"); or (3) returning to the United States after 180 days abroad if they already have legal permanent residency.[3] Current "legal permanent residents" (LPRs), humanitarian visa recipients and applicants (e.g., asylees and refugees), and other select groups *have not* previously been subject to public charge determinations and *would not* be under this proposed rule.[4]

The DHS proposal makes two major changes to public charge evaluations, as shown in Table 1. **First, it redefines a public charge as an "alien who receives one or more public benefits" and drastically broadens the benefits from just cash or long-term institutionalization to many potentially life-saving programs.**[5] **Second, the proposal defines an enforceable list of factors to consider under the "totality of circumstances" test in making public charge determinations (**see Appendix A for a full list of public programs and detailed description of factors considered).[6]

Table 1. A Summary of the Proposed Two-Part Public Charge Test[7]

MEANS-TESTED PUBLIC BENEFITS	TOTALITY OF CIRCUMSTANCES
SSI	Age
TANF (Temporary Assistance for Needy Families)	Health
Federal,* state, or local cash assistance	Family size
SNAP*	Assets
Section 8 housing voucher*	Resources
Section 8 rental assistance*	Financial status
Subsidized public housing*	Education
Medicaid (full-scope)*	Skills
Medicare Part D Low-Income Subsidy*	
Institutionalized long-term care	

**New benefits considered under the proposed rule*

Historical Chilling Effects

Extensive research has documented that the last time major welfare reform occurred, codified by the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA), immigrant families decreased their public benefits participation dramatically.[8] Although PRWORA only restricted the use of public benefits for the first five years of legal permanent residency, the concurrent timing of PRWORA with the Illegal Immigration Reform and Immigrant Responsibility Act along with the complexity of both laws led to fear and confusion for numerous immigrant households.[9] Many incorrectly believed they were no longer eligible for public benefits, that public benefits use would make them ineligible for naturalization, or that the government was tracking them.[10]

Following the passage of these laws, depending on the program, up to 60% of the eligible LPRs, other lawfully present noncitizens (e.g., refugees), and children in mixed-status families disenrolled from Medicaid, SNAP, and other public benefits programs; this disenrollment pattern was not seen among naturalized and native-born citizens.[11] **For Medicaid specifically, studies found a 15-36% drop in enrollment during this period.**[12] Historically, immigrant households have reduced health services utilization when immigration enforcement has increased, likely out of fear over how participation in these programs would affect their lives[13]

> **...most experts estimate that anywhere from 15–35% of the current chilled population will disenroll from public benefits programs in response to the proposed public charge rule change.**

Chilling Effects Today

The vast majority of those subject to public charge determinations are ineligible for public benefits. This is because citizenship, legal permanent residency, or a humanitarian visa, are generally program eligibility requirements (see Appendix B for a list of public benefits programs

and eligibility requirements).[14] Nonetheless, substantial numbers of lawfully present immigrants not subject to the benefits test are expected to curb their public benefits usage.[15] Additionally, because mixed-status families face a higher risk of separation through deportation, it is possible that such families with undocumented parents and/or siblings may feel the burden of the new public charge rule more strongly than families in which all members are legally present.[16]

Anecdotally, clinicians and service providers have already reported increased fear and decreased use of medical services among immigrant families in response to the general anti-immigrant rhetoric stemming from the 2016 presidential election, with upticks related to public charge announcements and leaks.[17] Given patterns of disenrollment following the passage of PRWORA, most experts estimate that anywhere from 15-35% of the current chilled population will disenroll from public benefits programs in response to the proposed public charge rule change.[18] Even DHS predicts that many in the chilled population will disenroll, resulting in an annual reduction of $2.27 billion in payments from the federal government to state governments for benefits programs.[19]

PROJECTED CONSEQUENCES OF RULE CHANGE

Projected Disenrollment

Immigration experts have used different methodologies and datasets to provide a range of estimates of the chilled population. For our analysis, we rely on reports from the UCLA Center for Health Policy Research (CHPR), which estimated the chilled population enrolled in Medi-Cal to be 2,116,000 people.[20] In order to make economic impact predictions, CHPR defines the chilled population more narrowly than other researchers by only including individuals who are receiving federally funded full-scope Medi-Cal.[21] This definition underestimates the true chilled population because it does not count legal permanent residents (LPRs) with less than five years of residency who receive state-funded Medi-Cal benefits.[22]

Using CHPR's estimates and assuming a 15-35% disenrollment rate, we calculate that 317,000 to 741,000 chilled people will disenroll from Medi-Cal (for a breakdown by age and race/ethnicity of predicted disenrollment, see Appendix C).[23] "Chilled people" refers to noncitizen immigrants and their dependents who are eligible for and enrolled in Medi-Cal but are at risk of disenrolling due to fear of negative immigration consequences. However, our research suggests a 15% disenrollment scenario is more likely given how the proposed rule has not received as much media attention as welfare reform did in 1996.[24] Hence, fewer families may be aware of changing regulations surrounding benefits use as they relate to immigration policy.

Health Impacts of Disenrollment

Prior research suggests that the expected disenrollment from Medi-Cal may cause burdensome health impacts on immigrant families. Quasi-experimental studies on states that expanded Medicaid coverage to childless non-elderly adults (19 to 64 years of age) in the 2000s found significant declines in mortality for this population, with the most recent analysis finding that one life was saved for every 239 to 316 adults gaining coverage.[25] Conversely, Medi-Cal disenrollment could lead to increased adult mortality. If losing Medi-Cal coverage has a similar size effect on the 104,000 adults in the chilled population who disenroll (i.e., 15% of 693,000 chilled adults), then we expect an additional 329 to 435 adult lives lost each year.[26]

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Economic Impacts of Disenrollment

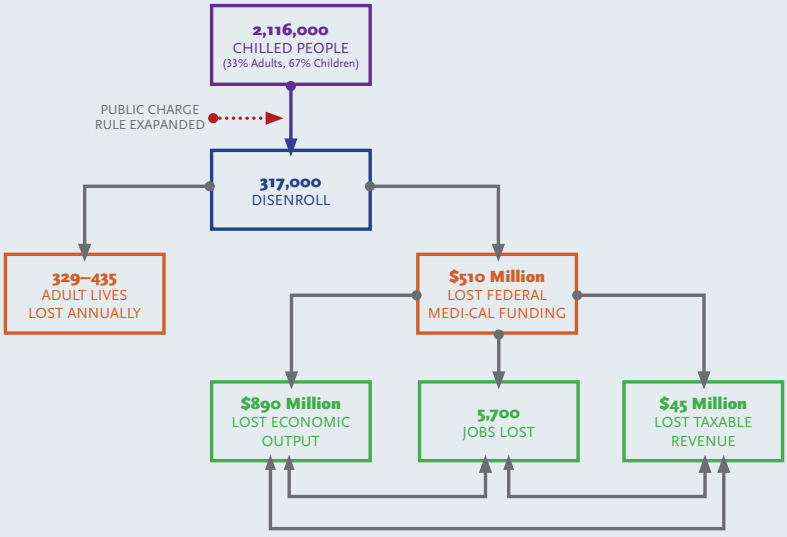
The projected disenrollment from Medi-Cal may have negative economic ramifications for the chilled population, including additional strain on individuals who are likely already financially insecure.[27] Because immigrants often work in industries with low rates of employer-based health insurance, they are far less likely than citizens to have alternative options for medical coverage.[28] By losing Medi-Cal, many chilled people will be forced to pay out-of-pocket for medical expenses.[29] These high medical costs, compared to the virtually negligible out-of-pocket costs while on Medi-Cal, can financially devastate families through massive debt, garnished wages, or even bankruptcy.[30] Furthermore, individuals in the chilled population may skip doctor visits and delay care because of high medical costs.[31] With minimal access

to paid sick leave, due to the nature of the industries in which immigrants are most likely to be employed, many will need to miss work without pay when ill.[32]

> **California could lose $510 million in federal Medi-Cal funding that would have gone to hospitals, medical laboratories, insurance providers, and other health care entities.**

In addition to individual financial burdens, lost federal funding due to Medi-Cal disenrollment would have negative ripple effects across California's economy.[33] To gauge these state-level fiscal impacts, we adjust the estimates of economic losses initially calculated by CHPR at a 35% disenrollment scenario to our assumed 15% disenrollment rate.[34] We determined that California could lose $510 million in federal Medi-Cal funding that would have gone to hospitals, medical laboratories, insurance providers, and other health care entities.[35] Ripple effects from these lost funds will then lead to an estimated loss of 5,700 jobs, a decrease in $890 million of economic output and a reduction in $45 million in taxable revenue.[36] CHPR expects 68% of these job losses to occur in the health care, real estate, and food industries.[37]

Figure 1. Projected Consequences of 15% Disenrollment by the Chilled Population[38]



While the ripple effects on jobs, economic output, and taxable revenue independently influence each other, they are ultimately the result of lost federal funding. On top of lost federal funding, newly uninsured families would be unable to pay for a high portion of out-of-pocket medical expenses, resulting in an increase in unreimbursed services to the hospitals that provide them.[39] This cost would then become the responsibility of health care systems, especially non-profit hospitals, which generally absorb unreimbursed costs when uninsurance rates rise.[40] The total negative health and economic impacts of the proposed public charge rule will likely be even greater given that enrollment is expected to decline in other public benefits programs as well.

POLICY EVALUATION

Criteria for Evaluating Policies

During the course of the data collection process, we identified 25 policy alternatives that could potentially mitigate the new public charge proposal (see appendix D). We evaluated policy alternatives based on their (1) efficacy, (2) cost of implementation, (3) cost-effectiveness ratio, and (4) political feasibility.[41]

Efficacy is the likely number of chilled people (i.e., lawfully present immigrants and citizen children with noncitizen parents enrolled in federally funded Medi-Cal) whose enrollment (or continued enrollment) in Medi-Cal is a result of the policy intervention.

Cost of implementation is the total identifiable direct costs to government at the state-level. We include costs for increased state spending on Medi-Cal beneficiaries who were previously uninsured but exclude costs related to improved renewal rates of existing Medi-Cal beneficiaries, consistent with state's legislature's cost calculation.[42] We exclude administrative costs and cost of downstream impacts (lost jobs and economic output from our calculations.

Cost-effectiveness ratio is the projected cost divided by projected efficacy (i.e., dollars per person diverted from disenrollment).All else being equal, policy options with greater cost-effectiveness are preferable as they provide "more bang for the buck."

Political feasibility is the likelihood of a policy of being passed into law given California's current political climate.[43] We define "high" political feasibility as passing with *minimal* lobbying of the California legislature and governor; "medium" political feasibility as requiring *significant* lobbying by advocates for passage; and "low" political feasibility as *unlikely to pass* in this political context despite significant lobbying. We also consider whether a window of opportunity for passage (a "policy window") is currently open given the current political landscape in California.[44] We base these rankings on evidence from news articles, our political feasibility survey, and informant interviews on the current political climate and historical contentiousness of similar policies.[45]

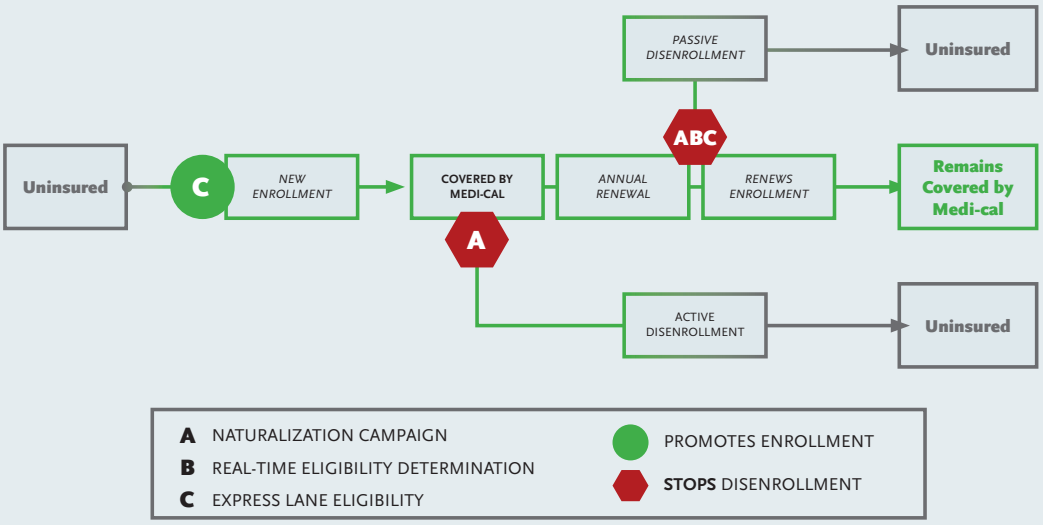
Policy Evaluation Method

We (1) consider all policy alternatives generated that could mitigate chilling effects with sufficient data to evaluate them based on the selected criteria and (2) recommend the option with the highest efficacy among politically viable options with the least tradeoff in cost and cost-effectiveness.

Final Policy Options for Analysis

Of all the policies considered, we determined that three options might improve Medi-Cal enrollment while also having sufficient data to make predictions about cost, efficacy, and political feasibility: (**1) Express Lane Eligibility (ELE), (2) a naturalization campaign**, and **(3) Real-Time Eligibility Determination (RTED)**[46]. We show how these policy options address the reasons why chilled people may disenroll or be uninsured in Figure 2. In evaluating these alternatives, we assume statewide implementation to maximize reach, although they could be implemented at a more local level to reduce costs (at the expense of efficacy).

Figure 2. Model of why chilled people are uninsured and how to intervene



EVALUATING EXPRESS LANE ELIGIBILITY (ELE)

Efficacy

We estimate the *uptake* portion of efficacy (i.e., new Medi-Cal enrollments) for Express Lane Eligibility (ELE) by considering the number of uninsured noncitizens and their dependents who are enrolled in WIC or CalFresh and could subsequently enroll in Medi-Cal through ELE. We assume that *all* of these individuals would consent to automatic enrollment in Medi-Cal given that they are already receptive to the idea of using public benefits, resulting in an **overestimate**.[47]

To estimate the *retention* portion of efficacy (i.e., number of chilled people who would now renew Medi-Cal instead of passively disenrolling), we start by estimating how many chilled people are dually enrolled in Medi-Cal and another benefits program. To simplify our calculation, we assume that all chilled people who disenroll from Medi-Cal would do so passively during annual renewal periods unless they could be automatically renewed through ELE or another mechanism. In other words, only those who are required to manually renew (e.g., by submitting income-verification paperwork) are at risk of disenrolling.[48] Currently, 40% to 60% of all Medi-Cal beneficiaries must go through manual renewal processes.[49] We predict that 15% of dually enrolled chilled people will be diverted from passive disenrollment through the auto-renewal feature of ELE. Because a small number of beneficiaries will actively disenroll instead of passively disenrolling, this results in an **overestimate**.

For our total efficacy estimate, we combine our uptake and retention efficacy estimates. Because both values are overestimates, our final efficacy estimate is also an **overestimate**. We conclude that WIC ELE has the potential to increase Medi-Cal enrollment by up to **154,000 chilled people**, which is likely an **overestimate** for reasons previously stated.[50]

Cost

We rely on multiple cost analyses of previous bills and programs for ELE and ELE-like programs from California legislative committees, the Legislative Analyst's Office, and The Children's Partnership to determine the cost of implementation for ELE.

The California Senate estimated that AB 2579 (Burke, D-Inglewood), which would have authorized WIC ELE, would have cost $1.1 to $1.6 million in technological changes.[51] Additionally, they also estimated that state funding in the amounts of $10 to $23 million in FY 2019-2020 and $50 to $250 million in FY 2020-2021 would have been required to absorb the cost of new enrollees.[52] This brings the total cost estimate from the Senate to $61 to $275 million over two years. In comparison, The Children's Partnership calculated that the annual cost of WIC ELE proposed in AB 526 (Petrie-Norris, D-Laguna Beach) would be **$104 million**, which includes the cost of new enrollees and implementation/administrative costs.[53] We favor this estimate rather than the Senate's, as it uses an average per-person cost similar to that found in other literature.[54] Additionally, this program cost of $104 million is relatively high but accounts for increased enrollment from all Californians, not just the chilled population in California.

Cost-Effectiveness Ratio

With an extra 154,000 chilled people receiving Medi-Cal coverage at a cost of $104 million, WIC ELE has a cost-effectiveness ratio of **$675 per person**.

Political Feasibility

Survey respondents were split about political feasibility of Express Lane Eligibility. Those who felt it was viable generally agreed that ELE would face significant challenges to pass, perhaps

because respondents were aware that previous ELE legislative proposals had faced obstacles. However, ELE would likely appeal to a broad coalition of organizations and legislators interested in expanding medical coverage because it simplifies enrollment and renewals for *all* Medi-Cal eligible Californians, not just those in the chilled population. In this sense, ELE would provide concentrated benefits to those who are Medi-Cal-eligible and diffused costs, providing a reasonable basis for political mobilization by health and immigrant rights advocates.[55]

According to The Children's Partnership, which lobbied for AB 2579 (Burke, D-Inglewood) in 2018, support from legislators for this WIC ELE bill initially appeared promising.[56] Reportedly, a lack of support from then-Governor Brown eventually led AB 2579 to stall in the Senate Appropriations Committee.[57] Nonetheless, advocates have renewed confidence in the recently introduced AB 526 (Petrie-Norris, D-Laguna Beach) that authorizes WIC ELE given that newly-elected Governor Newsom has made it a priority to invest significantly in healthcare expansion for immigrants.[58] An anonymous expert familiar with this legislation further substantiated this claim stating that the election of Governor Newson has built momentum and created a policy window for WIC ELE via AB 526.[59] In fact, advocates recently sent a budget request letter to the Governor's office in an effort to concretely define his position on the bill and build support for AB 526.[60] However, despite Governor Newsom's support, this policy would still likely require stakeholders to advocate directly the Assembly and Senate Appropriations and Budget Committees ahead of its passage.[61] Thus, we predict that WIC ELE, as it would be established through AB 526, will have **medium political feasibility.**

POLICY RECOMMENDATION

In order to best mitigate disenrollment from Medi-Cal by the chilled population, we recommend that the California Immigrant Policy Center (CIPC) and its partners support the authorization and implementation of Express Lane Eligibility (ELE) as it offers the highest efficacy (see Table 2 for a summary of our policy evaluation). We specifically recommend supporting the newly introduced Assembly Bill (AB) 526 (Petrie-Norris, D-Laguna Beach), which authorizes ELE based on the Special Supplemental Program for Women, Infants, and Children (WIC) in California, rather than introducing a competing CalFresh ELE legislative proposal.[62] Although both forms of ELE would likely provide similar efficacy, our analysis indicates that WIC ELE has greater political viability given the increasing political momentum around this option and projected lower costs (about half that of CalFresh ELE).

Table 2. Summary of Policy Evaluation

CRITERIA	Naturalization Campaign	Real Time Eligibility Determination: California Healthcare Eligibility Enrollment and Retention System	Real Time Eligibility Determination: SAWS	WIC ELE	CalFresh ELE
Efficacy	5,000 to 17,000	41,000	105,000	154,000	143,000
Cost of Implementation *Adjusted for inflation (2019)*	Donations: $15M to $47M Fully funded: $23M to $70M	$363,000	$1 million	$104 million	$224 million
Cost-Effectiveness Ratio	Donations: $1,458/ person Fully funded: $2,178/ person	$3 to $9 per person	$10 to $24 per person	$675 per person	$1,560/ person
Political Feasibility	High	Low	Low	Medium	Low

As one of the most expensive policy options considered, AB 526 may still face significant challenges as it moves through the state legislature. Supporters of the bill have approached this hurdle by suggesting that enrollment could be spread out over time rather than automatically enrolling everyone identified through WIC ELE at once, distributing the cost and administrative burden.[63]

Real-time eligibility determination (RTED) offers the second greatest efficacy (roughly half that of ELE) at a significantly lower cost and better cost-effectiveness ratio than either ELE or a naturalization campaign. This would have made RTED a reasonable alternative if it had better political feasibility and if budget limitations were a concern. Unfortunately, its low political feasibility due to a strong resistance from county administrators who value the status quo makes RTED a non-viable option at this time.[64] In order to increase the political feasibility of RTED, country administrators would have to buy into this option because both mechanisms for expanding this provision require changes at the county level.

Although a naturalization campaign is highly politically feasible, this option has the lowest predicted efficacy with the worst cost-effectiveness ratio of the three options considered. While we do not recommend a naturalization campaign to mitigate Medi-Cal disenrollment, a relatively small change to the existing One California program (by sending fee waiver eligibility notices) could potentially improve naturalization rates and thus improve Medi-Cal participation.[65] Furthermore, there are many other potential benefits to naturalization, including economic mobility, reduced fear, and expanded civic participation.[66]

IMPACTS OF WIC EXPRESS LANE ELIGIBILITY

For our policy recommendation of Express Lane Eligibility (ELE) based on enrollment in the Special Supplemental Program for Women, Infants, and Children (WIC), we estimate that improving Medi-Cal enrollment by 40,000 adults will save 128 to 169 lives per year, as shown in Table 3.[67] Moreover, keeping a total of 154,000 chilled adults and children enrolled would protect an estimated $247 million in federal Medi-Cal funding. We predict that this improvement in federal funding would, in turn, save up to 2,800 jobs, improve economic output by $432 million, and increase taxable revenue by $22 million, compared to if no intervention was provided. While WIC ELE is the most expensive policy option considered, the cost savings it provides by improving Medi-Cal participation clearly still outweighs its projected cost of $104 million annually. Moreover, if chilled people disenroll at higher rates than our conservative estimate of 15%, then the impacts of our policy recommendation will be even greater, easing the lives of so many in California.

Table 3. Predicted Improvements in the Health and Economic Consequences of the Proposed Public Charge Rule Due to WIC ELE*

IMPACT	NO INTERVENTION	IMPACT OF WIC ELE*
Efficacy	317,000 ***disenrollees*** (104,000 adults)	154,000 ***diverted from disenrollment*** (40,000 adults)
Mortality	329-435 adult lives ***lost*** annually	128 - 169 adult lives ***saved*** annually
Federal Funding[68]	$510M ***lost***	$247M ***saved***
Jobs	5,700 jobs ***lost***	2,800 jobs ***saved***
Economic Output	$890M ***lost***	$432M ***saved***
Taxable Revenue	$45M ***lost***	$22M ***saved***

**All numbers have been rounded*[68]

APPENDICES

Appendix A: Details of the Proposed Public Charge Rule

Factors Considered for the "Totality of Circumstances" Aspect of the Public Charge Rule[69]

POSITIVELY WEIGHTED FACTORS	NEGATIVELY WEIGHTED FACTORS
Financial • Financial assets, resources, and support of at least 250% FPL • Good credit and credit score • Sponsor with assets and resources at or above 125% FPL **Employment** • Occupational skills, certifications, or licenses • Work authorization and current employment with income of at least 250% FPL	**Financial** • Income below 125% FPL • Family size compared to assets and resources **Employment** • Have work authorization and not a full-time student, but is unemployed with no employment history or prospects for future employment **Education** • Does not speak English well or at all • No high school diploma **Age** • Under 18 or over 61 **Health Status** • Medical condition and inability to obtain unsubsidized health insurance now or in the future or other ways to pay for treatment **Other** • Use of one or more public benefits within the last 36 months • Previous determination of inadmissibility or deportability

Note: *Factors listed in the table are not intended to be comprehensive and are intended rather to demonstrate examples of factors that can be either be positively or negatively weighed. Table does not illustrate a quantifiable weight for each factor listed.*

Public Benefits Considered[70]

- Any federal, state, local or tribal financial assistance, including Supplemental Security Income (SSI) and Temporary Assistance for Needy Families (TANF)
- Supplemental Nutrition Assistance Program (SNAP)
- Section 8 vouchers or project-based rental assistance
- Federal Public Housing Programs
- Medicaid
- Any benefit provided for long-term institutionalization at government expense
- Premiums and cost-sharing for Medicare Part D

Appendix B: Eligibility Requirements for Major Benefit Programs in California

Note: Legal permanent residents (LPRs), refugees, asylees, and humanitarian visa holders (e.g. U Visa, T Visa, etc.) are the largest groups of "Qualified Immigrants" eligible for the programs below, unless otherwise noted. For exceptions to requirements other than immigration status, please visit the program eligibility websites cited in the footnotes.[71] [72]

PROGRAM	DESCRIPTION	IMMIGRATION STATUS[72]	INCOME & ASSETS	AGE
Medi-Cal[73]	Medical insurance for low-income adults, children, and women who are pregnant	Full-Scope: All children eligible Restricted: All eligible	Less than 138% FPL	Below 64
Medicare Part D Low Income Subsidy[74]	Covers prescription drugs for low-income seniors enrolled in Medicare	LPR: At least 5 years residency	Full: Less than 135% FPL Partial: 135% to 150% FPL	Over 65
Institutionalization for Long-Term Care[75]	Nursing home; convalescent care; preventive, primary, and specialty care services	Emergency Services: All eligible	Income: No limit (patient); Can keep $3,023 per month (spouse) Assets: Less than $2,000 (patient); less than $120,900 (spouse)	Psychiatric: Under 21 Mental Health: Over 65
SNAP (CalFresh)[76]	Nutrition assistance for low-income families and individuals ("food stamps")	LPR: At least 5 years residency + 40 quarters of work	Less than 200% FPL	Below 18
Public Housing[77]	Federal program which houses families with low-incomes, people with disabilities, and elderly individuals	N/A	Less than half of county/metropolitan median income; limited units for 50-80% median income	N/A
Section 8 - Housing Voucher and Project-Based Rental Assistance[78]	Federal program which assists families with low-incomes, people with disabilities, and elderly individuals in finding housing	N/A	Less than 30-50% of median income for county/metropolitan area; limited units for 50-80% median income	N/A

PROGRAM	DESCRIPTION	IMMIGRATION STATUS[72]	INCOME & ASSETS	AGE
TANF (CalWorks)[79]	Temporary financial assistance; includes education and job programs	N/A	Family of 4 income is less than $1655 or $1574 based on region Family has $2250 or less in resources excluding value of home, car and others[80]	N/A
SSI[81]	Monthly cash assistance to low-income people, the disabled, blind, or elderly	LPR: At least 5 years residency + 40 quarters of work Refugee/Asylee: At least 7 years residency	Income: Less than $750/month Assets: Less than $2000 (single) or less than $3,000 (married couple)	65 and over Children who are blind or disabled
Cash Assistance Program for Immigrants (CAPI)[82]	State program providing financial assistance to those who meet all eligibility criteria for SSI other than immigration status	All eligible	Income: Less than $750/month Assets: Less than $2000 (single) or less than $3,000 (married couple)	65 and over Children who are blind or disabled

Appendix C: Chilled Population by Age and Race/Ethnicity[83]

Estimated Chilled Population by Age

AGE	NUMBER OF CHILLED PEOPLE	% OF CHILLED POPULATION
Adults	693,000	33%
Children	1,423,000	67%
Total	2,116,000	100%

Estimated Chilled Population by Race/Ethnicity

RACE/ ETHNICITY	NUMBER OF CHILLED PEOPLE	% OF CHILLED POPULATION
White	36,000	2%
Latino	1,869,000	88%
Asian	177,000	8%
Other	34,000	2%
Total	2,116,000	100%

Appendix D: Eliminated Policy Options

INSUFFICIENT EFFICACY AND/OR COST DATA

FEAR REDUCTION

1. Strategic **voter registration & engagement** to replace current leaders with more immigrant friendly lawmakers and administration.

2. **Eliminate notarios** and immigration consultants who pose as attorneys and/or give incorrect legal advice by funding investigations (e.g. private shopper-like stings), increasing penalties and fines, enforcing existing punishments, and revoking licenses.

3. Place more **legal or structural barriers** between community clinics and the federal government (e.g. firewalls or a health care specific Trust Act).

4. **Education campaign** targeting immigrant families: community workers, trusted entities (ethnic media outlets, schools, and clinics), social media in multiple languages, hotline, posters and informational sheets in clinics, informational mailers (especially during renewal periods), Note: This must be handled carefully to avoid stoking fear if immigrant families are relatively unaware of public charge.

5. Disconnect medical services from legal identifiers by assigning **patient identification cards** that are not linked to legal identities at community health centers.

INCREASE MEDI-CAL ENROLLMENT (UPTAKE)

6. Targeted **sign-up campaigns** using ACA strategies (e.g. in-person help for Latinos).

7. **Reduce reading level** of enrollment materials.

8. A new **joint enrollment and renewal process** for Medi-Cal, combining state and county systems to utilize the different capabilities of either system to automate the enrollment and renewal process (this option may also help with retention).

IMPROVE MEDI-CAL RENEWAL RATES (RETENTION)

9. **Pre-completed renewal forms** requiring only a signature.

10. Train benefits administrators to ask why a patient would like to disenroll and then **provide education, reassurance, and encouragement** to stay enrolled (similar to the process for stopping paid subscription services).

11. **Enroll children for two to five years** instead of one year (possible through a federal waiver after demonstrating that this would be cost neutral).

ALTERNATIVE HEALTH COVERAGE

12 Employer-focused subsidies or other incentives to **expand work-based insurance**, particularly in service and gig economy sectors.

13 **Expand the scope of public health clinics** from infectious diseases to chronic conditions like diabetes, heart disease, obesity, etc. to give uninsured individuals another source of care.

14 **Subsidize sliding scale providers**.

POVERTY REDUCTION

15 Expand **state and county funded cash and food assistance** programs.

16 Cal-Earned Income Tax Credit (**Cal-EITC**).

17 **Raise minimum wage** (however, minimum wage will already be $15 by 2022-2023).

EMPLOYMENT FOCUSED

18 **Workforce development**: Improve access to jobs with better benefits.

19 Encourage **participation in unions or worker collectives** that offer insurance.

20 **Empower unions and worker collectives** to better protect workers from employment abuse and improve wage bargaining power.

21 **Enforce existing employment protections.**

22 **Strengthen employment protections**, e.g. simplify the grievance process.

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Laurel Lucia (Director, Health Care Program, UC Berkeley Labor Center), email message to an author, January 18, 2019.

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47 Presumably, those who are enrolled in WIC or CalFresh, but not in Medi-Cal, do not know about their Medi-Cal eligibility or had difficulty signing up for Medi-Cal. These are the same general reasons that most other uninsured, but Medi-Cal eligible people lack coverage.

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Kristen Golden Testa (Director of California Health Program, The Children's Partnership), email message to an author, February 7, 2019.

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Kristin Golden Testa (Director of California Health Program, The Children's Partnership), email message to an author, January 24, 2019.

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ABOUT CIPC

The California Immigrant Policy Center (CIPC) is a constituent-based statewide immigrant rights organization with offices in Los Angeles, Sacramento, San Diego and Oakland. It is the premiere immigrant rights institution in the state that promotes and protects safety, health and public benefits and integration programs for immigrants, and one of the few organizations that effectively combines legislative and policy advocacy, strategic communications, organizing and capacity building to pursue its mission. It is powered by a staff of policy experts and advocates; a Steering Committee composed of 14 statewide organizations; 85 member organizations; and nine regional coalition partners spanning Southern and Northern California, the Central Coast and the Central Valley.

For the past 20 years, CIPC has played a central and essential role in advancing a progressive statewide immigrant justice agenda. For the past 5 years, it helped pass 30 pro-immigrant laws in the state, including: The Safe and Responsible Driver Act, the TRUST Act, the One California initiative, the E-Verify Bill and the Health for All Kids among others – signature legislative accomplishments propelled by the organization's ability to coordinate, convene and mobilize a broad and diverse array of advocates towards a common goal.

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