

PUBLIC CHARGE AND THE THREAT TO IMMIGRANT FAMILIES IN CALIFORNIA

Reducing the Chilling Effect on
Medi-Cal Participation

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EXECUTIVE SUMMARY

On October 10, 2018, the U.S. Department of Homeland Security (DHS) 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. The proposed change expands the list of benefits considered in public charge determinations, including Medicaid (called Medi-Cal in California). As a result, experts predict that at least 15% of individuals in households with noncitizens (known as the “chilled population”) will disenroll from public benefits due to fear of negative immigration consequences (known as “chilling effects”). This means that of the 2,116,000 chilled Californians enrolled in Medi-Cal, at least 317,000 are predicted to disenroll, causing negative health impacts and economic damage.

Our client, the California Immigrant Policy Center (CIPC), is a 501(c)(3) organization that advocates for immigrants at the state and local levels. Its work on public charge is primarily focused on understanding how the proposed rule change will impact immigrant families and how to best mitigate its predicted adverse effects. As the chilled population is more likely to be enrolled in Medi-Cal than any other affected benefits program, this report asks the following policy question:

How can the California Immigrant Policy Center best mitigate the adverse effects on Medi-Cal disenrollment due to the Department of Homeland Security's proposed expanded definition of public charge?

Through literature reviews, expert interviews, and a survey, we determined that the most effective policy alternatives would reduce fear, increase new enrollments, and/or increase renewal rates. Three promising options emerged: (1) a **naturalization campaign** that would notify people of their eligibility for application fee waivers plus education and legal support; (2) **real-time eligibility determination (RTED)** to simplify and automate Medi-Cal enrollments and renewals; and (3) **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. We evaluated these policy alternatives on efficacy, cost of implementation, cost-effectiveness ratio, and political feasibility.

Based on these evaluations, **we recommend that CIPC support Express Lane Eligibility (ELE) based on the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC)**. With almost double the projected efficacy of the next best option (up to 154,000 beneficiaries enrolled as a result of the intervention), the authorization of WIC ELE in California with Assembly Bill 526 (Petrie-Norris, D-Laguna Beach) is the best option of those we explored to mitigate Medi-Cal disenrollment.

GLOSSARY

California Healthcare Eligibility, Enrollment and Retention System (CalHEERS): The statewide system that processes applications and eligibility determinations for Medi-Cal and California's ACA Marketplace, Covered California

Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA): Federal legislation that gives states significant funding and programmatic options to provide health insurance for children through Medicaid and CHIP

Express Lane Eligibility (ELE): A CHIPRA provision that allows a child's enrollment data in one means-tested public benefits program to verify eligibility for Medicaid or CHIP

Express Lane Enrollment: A now-defunct California program that automatically enrolled uninsured adult beneficiaries of CalFresh into Medi-Cal

Legal Permanent Resident (LPR): A type of noncitizen immigrant who is legally allowed to live in the United States; a "green card" holder

Medicaid (or Medi-Cal in California): A federal and state program that provides medical insurance coverage to certain low-income people

Mixed-Status Family: A family consisting of individuals with different immigration statuses, e.g., citizen children with noncitizen parents

Naturalization: The legal process through which an immigrant becomes a U.S. citizen, which includes passing an English and civics test

Public Charge - Current Definition (Since 1996): A person who is primarily dependent on the government for survival based on receipt of public cash assistance or government-funded institutionalization for long-term care; can be denied legal permanent residency or admission to the United States

Public Charge - Proposed Definition: A person who receives one or more public benefits

Real-Time Eligibility Determination (RTED): Almost instantaneous eligibility determination for Medicaid applications; facilitated by federal and state electronic databases

Semi-Structured Interview: when the interviewer does not strictly follow the predetermined list of questions to allow for new concepts to be introduced by the interviewee

Statewide Automated Welfare System (SAWS): California's county-based systems that process applications and determine eligibility for public benefits programs

Section 8: A federal program that provides housing assistance in the form of rent support or public housing to certain low-income families, disabled people, and the elderly

Supplemental Nutrition Assistance Program (SNAP, or CalFresh in California): A federal program that provides food assistance to certain low-income people

Temporary Assistance for Needy Families (TANF, or CalWORKs in California): A federal and state financial assistance program for low-income families with children

The Special Supplemental Nutrition Program for Women, Infants and Children (WIC): A federal program that provides healthcare and nutrition assistance to certain low-income pregnant women, breastfeeding women, and children under the age of 5

ACRONYMS AND INITIALISMS

ACA: Patient Protection and Affordable Care Act

CalHEERS: California Healthcare Eligibility, Enrollment and Retention System

CHIP: Children's Health Insurance Program

CHIPRA: Children's Health Insurance Program Reauthorization Act

CHIS: California Health Interview Survey

CHPR: Center for Health Policy Research

CIPC: California Immigrant Policy Center

CSII: Center for the Study of Immigrant Integration

DACA: Deferred Action for Childhood Arrivals

DHCS: Department of Health Care Services

DHS: Department of Homeland Security

ELE: Express Lane Eligibility

ETN: a person who is eligible to naturalize

FPL: Federal Poverty Level

LPR: legal permanent resident

PIF: Protecting Immigrant Families

RTED: real-time eligibility determination

SAWS: Statewide Automated Welfare System

SNAP: Supplemental Nutrition Assistance Program

TANF: Temporary Assistance for Needy Families

WIC: The Special Supplemental Nutrition Program for Women, Infants and Children

CHAPTER 1 INTRODUCTION

When presidential candidate Donald Trump launched his bid for the presidency, he marked the occasion with a brash reference to Mexican immigrants as criminals, only conceding that “some... are good people.”¹ As the campaign continued, so did his oversimplified, caustic rhetoric surrounding immigrants.² Although this discourse often centers around people from Mexico and Central America crossing the U.S.-Mexico border, immigrants have arrived from other regions like Asia at higher rates in recent years.³ Accompanying these changes is the reality that as American cultural, racial, and ethnic diversity increases, so do the fears and anxieties of many native-born citizens over this diversification.⁴

In an effort to satisfy such nativist sentiments, President Trump has introduced policies to limit new immigration and target existing low-income immigrants by proposing an expansion to the “public charge” test through a new Department of Homeland Security (DHS) rule.⁵ Currently, the rule determines an immigrant to be a public charge if they primarily depend on cash assistance or long-term institutional care provided by the government, which can bar them from gaining a legal permanent residency or entering the country.⁶ The expansion would redefine a public charge as a person who uses one or more public benefits.⁷ This change would likely create a “chilling effect” where benefits-eligible immigrants and citizen children in immigrant households (i.e., the “chilled population”) would forgo those benefits out of misplaced fear of draconian immigration consequences.⁸ While the proposed rule is

1 Jonathan Capehart, “One Year Ago, Trump Descended That Escalator and Took Political Discourse down with Him,” *The Washington Post* (WP Company, June 15, 2016), https://www.washingtonpost.com/blogs/post-partisan/wp/2016/06/15/one-year-ago-trump-descended-that-escalator-and-took-political-discourse-down-with-him/?utm_term=.349effdb7801.

2 Jonathan Martin, “Donald Trump’s Barrage of Heated Rhetoric Has Little Precedent,” last modified December 21, 2017, <https://www.nytimes.com/2016/10/15/us/politics/trump-speech-highlights.html>.
Harold Trinkunas, “Rhetoric of This Year’s Presidential Campaign Is No Substitute for Thoughtful Policy,” Brookings (The Brookings Institution, September 14, 2016), <https://www.brookings.edu/blog/up-front/2016/09/06/rhetoric-of-this-years-presidential-campaign-is-no-substitute-for-thoughtful-policy/>.

3 James M. Lindsay and Audrey Singer, *Changing Faces: Immigrants and Diversity in the Twenty-First Century*, rep., (The Brookings Institution, June 1, 2003), <https://www.brookings.edu/wp-content/uploads/2016/06/20030601-2.pdf>, 217.
Jessica Bolter, “The Evolving and Diversifying Nature of Migration to the U.S.-Mexico Border,” Migration Policy Institute, February 16, 2017, <https://www.migrationpolicy.org/article/evolving-and-diversifying-nature-migration-us-mexico-border>.

4 Lindsay and Singer, *Changing Faces*, 218-219.

5 Sarah Pierce and Andrew Selee, “Immigration under Trump: A Review of Policy Shifts in the Year Since the Election,” issue brief (Migration Policy Institute, 2017), <https://www.migrationpolicy.org/research/immigration-under-trump-review-policy-shifts>.
Alicia Wilson and Catalina Sol, “A Proposed New ‘Public Charge’ Rule Puts Children’s Health Insurance at Risk,” last modified December 18, 2018, https://www.washingtonpost.com/outlook/2018/12/18/proposed-new-public-charge-rule-puts-childrens-health-insurance-risk/?utm_term=.cdee35ce9af9.
Immigrant Legal Resource Center. “Public Charge,” Immigrant Legal Resource Center | ILRC, accessed January 15, 2019, <https://www.ilrc.org/public-charge>.

6 Jeanne Batalova, Michael Fix, and Mark Greenberg, “Chilling Effects: The Expected Public Charge Rule and Its Impact on Legal Immigrant Families’ Public Benefits Use,” migrationpolicy.org, June 2018, <https://www.migrationpolicy.org/research/chilling-effects-expected-public-charge-rule-impact-legal-immigrant-families>, 6.

7 Department of Homeland Security, “Inadmissibility on Public Charge Grounds,” *Federal Register* 83, no. 196 (October 10, 2018): 51114-51296.

8 We use the term “immigrants” throughout this report to mean immigrant adults and children who have not naturalized and gained citizenship, unless otherwise noted.
Batalova, Fix, and Greenberg, “Chilling Effects.”

subjected to formal administrative procedures ahead of its adoption, immigrant families, advocates, attorneys, and policy leaders are faced with a quagmire of uncertainty, confusion, and fear over the final iteration of the rule and how it will be implemented.⁹

Client Background

The California Immigrant Policy Center (CIPC) is a 501 (c) (3) nonprofit advocacy group, dedicated to "promoting and protecting the safety, health, public benefit access, economic well-being and integration programs for immigrants."¹⁰ As a statewide operation, it is "one of the few organizations that effectively combines legislative and policy advocacy, strategic communications, organizing and capacity building to pursue its mission."¹¹ Founded in 1996 in response to California's Proposition 187, which aimed to block undocumented immigrants from using public benefits, CIPC is "a hub of reliable information, advocacy tools, education and research materials regarding California's immigrants and their economic, social, and demographic impact on our state and nation."¹² Armed with policy experts, legal experts, and trained advocates, CIPC has helped pass major statewide legislation to "protect immigrant rights, including the Safe and Responsible Driver Act, the TRUST Act, the E-Verify Bill, the California Values Act and Health4All Kids."¹³ In partnership with the Protecting Immigrant Families coalition, co-lead by the National Immigration Law Center and the Center for Law and Social Policy, which is the national leader driving public charge advocacy, CIPC anchors California's campaign to stop the expansion of the Public Charge rule.

Scope of Project

In an effort to lead a data-driven response to the proposed expansion of the public charge rule, CIPC has requested an analysis of (1) the predicted disenrollment by the chilled population from benefits programs impacted by the public charge provision, (2) other consequences of the proposed rule change, and (3) policy options to mitigate the fallout from expanding the definition of a public charge. Although experts predict that multiple benefits programs will see lower participation, leading to potentially significant harm for immigrant families, we have limited our analysis to focus on Medi-Cal as public charge impacts many more people who use this benefit than any other program.¹⁴ Through this analysis, we address the following question:

How can the California Immigrant Policy Center (CIPC) best mitigate the adverse effects on Medi-Cal disenrollment due to the Department of Homeland Security's proposed expanded definition of public charge?

This report provides CIPC with empirically informed data analysis by measuring some of the most significant potential impacts of the public charge rule change on immigrant families. We identify and evaluate possible ways to counter these adverse effects, culminating with an evidence-based policy recommendation that maximizes Medi-Cal enrollment among California's chilled population. Our objective for this data-driven approach is to support CIPC in its lobbying efforts should it choose to adopt and advocate for the policy option we recommend.

9 Zaidee Stavely, "Proposed 'Public Charge' Rule Change Stirs Confusion over Green Card Eligibility," last modified November 28, 2018, <https://www.pri.org/stories/2018-11-28/proposed-public-charge-rule-change-stirs-confusion-over-green-card-eligibility>.

10 Almas Sayeed (Deputy Director of Programs, California Immigrant Policy Center), email message to the authors, April 21, 2019. California Immigrant Policy Center. "About Us," California Immigrant Policy Center | Home, last modified 2018, <https://www.caimmigrant.org/about-us/>.

11 California Immigrant Policy Center, "About Us."

12 Ibid. "California Proposition 187, Illegal Aliens Ineligible for Public Benefits (1994)," Ballotpedia, accessed March 8, 2019, [https://ballotpedia.org/California_Proposition_187,_Illegal_Aliens_Ineligible_for_Public_Benefits_\(1994\)](https://ballotpedia.org/California_Proposition_187,_Illegal_Aliens_Ineligible_for_Public_Benefits_(1994))

13 Almas Sayeed (Deputy Director of Programs, California Immigrant Policy Center), email message to the authors, April 21, 2019. California Immigrant Policy Center, "About Us."

14 Batalova, Fix, and Greenberg, "Chilling Effects," 21.

CHAPTER 2

THE “PUBLIC CHARGE” RULE: CHILLING EFFECTS THEN AND NOW

The Proposed Rule Change

Consistent with the Trump Administration’s nativist immigration agenda, the Department of Homeland Security (DHS) proposed changes to the “public charge” rule on October 10, 2018, which is expected to curb legal immigration dramatically and harm immigrant families.¹⁵ 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.”¹⁶ Since then, immigrants deemed to be “public charges” or likely to become “public charges” 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.¹⁷ 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 still would not be under the proposed rule.¹⁸

As required by the Administrative Procedures Act (APA) of 1946, DHS held a 60 day public comment period on the proposed changes followed by a 30-day interagency comment period.¹⁹ In total, the public submitted over 260,000 comments to the federal government, over 60,000 of which DHS had reviewed and posted online at the time of publication.²⁰ Once DHS posts a written response to all public comments, it can finalize and implement the proposed rule in as quickly as 60 days. Once the rule is finalized, immigrant advocacy organizations plan to file lawsuits arguing that DHS violated APA guidelines by inadequately processing comments.²¹ In conjunction with these lawsuits, they also plan to request injunctions stopping implementation of the policy, potentially leading to a court battle lasting months to years.²²

15 Ted Hesson et al., “Immigrants May Be Denied Green Cards If They’ve Received Benefits,” *Politico*, September 22, 2018, <https://www.politico.com/story/2018/09/22/poor-immigrants-green-cards-trump-836456>.
Department of Homeland Security, “Inadmissibility.”

16 Dara Lind, “Trump’s Controversial ‘Public Charge’ Proposal That Could Change the Face of Legal Immigration, Explained,” *Vox.com* (Vox Media, December 10, 2018), <https://www.vox.com/2018/9/24/17892350/public-charge-immigration-food-stamps-medicaid-trump-comments>.

Illegal Immigration Reform and Immigrant Responsibility Act of 1996, 8 USC §§1182(a) (2019)

17 Immigration and Nationality Act, 8 USC §§1227 (2019).

18 Department of Homeland Security, “Inadmissibility.”

19 Administrative Procedures Act, U.S. Code 5 (1946), subch. I § 500 et seq.

20 “Inadmissibility on Public Charge Grounds,” *Regulations.gov*, last modified December 10, 2018, <https://www.regulations.gov/document?D=USCIS-2010-0012-0001>.

21 Connie Choi (Protecting Immigrant Families Campaign Field Manager and Strategist, National Immigration Law Center), in discussion with an author, Los Angeles, CA, January 7, 2019.

22 Connie Choi (Protecting Immigrant Families Campaign Field Manager and Strategist, National Immigration Law Center), in discussion with an author, Los Angeles, CA, January 7, 2019.

To receive an injunction, lawyers would need to show that significant, immediate harm would come from implementing the rule change.

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, including Medicaid (“Medi-Cal” in California), Supplemental Nutrition Assistance Program (SNAP, or “CalFresh” in California), Section 8 housing assistance, and the Medicare Part D low-income subsidy program (see Appendix A for a full list of programs).²³ Second, the proposal defines an enforceable list of factors to consider under the “totality of circumstances” test in making public charge determinations: age, health status, family size, income, assets, other financial resources, education, and skills (see Appendix A for a detailed description of factors considered).²⁴

Table 1. A Summary of the Proposed Two-Part Public Charge Test²⁵

Totality of Circumstances	Means-Tested Public Benefits
	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

Strikingly, most people who are eligible for the listed government benefits are not subject to public charge determinations (see Appendix B for a list of benefits and eligibility requirements).²⁶ As shown in Table 2, the only undocumented immigrants in California who could be subject to the benefits test in public charge determinations are undocumented pregnant women, undocumented children under 18, and Deferred Action for Childhood Arrivals (DACA) recipients who receive Medi-Cal.²⁷ Thus, few people are likely to face immigration consequences for the usage of such programs.²⁸

23 Department of Homeland Security, “Inadmissibility.”

24 Ibid.

Previously, these factors could theoretically be considered to determine whether a green card applicant was likely to become a public charge. Field guidance was only issued on how to consider public benefits usage, so there were no subsequent reports of systemic uses of the totality of circumstances test in reviewing green card applications.

Immigration and Naturalization Service, “Field Guidance on Deportability and Inadmissibility on Public Charge Grounds,” Federal Register 64 no. 28689, NS No. 1988-99 (May 26, 1999): 28689-28693, <https://www.federalregister.gov/documents/1999/05/26/99-13202/field-guidance-on-deportability-and-inadmissibility-on-public-charge-grounds>.

25 Ibid.

26 Randy Capps et al., “Gauging the Impact of DHS’ Proposed Public-Charge Rule on U.S. Immigration,” Migrationpolicy.org, last modified November 16, 2018, <https://www.migrationpolicy.org/research/impact-dhs-public-charge-rule-immigration>.

27 Undocumented adults in California are also eligible for restricted (“emergency”) Medi-Cal, but this is excluded in the proposed rule. Certain undocumented immigrants may also qualify for Medicaid in other states but are not uniformly eligible across the country. “Medi-Cal: The Details,” Disability Benefits 101: working with a disability in California (Disability Benefits 101 National, January 1, 2019), https://ca.db101.org/ca/programs/health_coverage/medi_cal/program2.htm.

28 Based on current immigration patterns, changes to the “totality of circumstances” factors would predominantly disadvantage women, children, the elderly, and non-European residents from immigrating to the United States (i.e., it would favor working-age men from European countries).
Ibid.

Table 2. Immigrants subject to public charge test and their likelihood of passing²⁹

	Not Subject to Test	Subject to Test, May Not Pass	Subject to Test, Unlikely to Pass
Legally Present <i>These adults and their dependents are the chilled population</i>	Current LPR Asylee/refugee Humanitarian visas	LPR returning from being abroad more than 180 days	N/A**
Lacking Visas	N/A	Undocumented pregnant women* Undocumented children (0-18)* DACA recipients*	Undocumented adults and children applying for adjustment of status** Aliens abroad applying for entry**

*Immigrants residing in certain states like California are eligible for Medicaid, making them susceptible to failing the public charge test. Immigrants in other states may not be Medicaid-eligible and thus unlikely to fail the test.

**These individuals are unlikely to fail the public charge test on the use of public benefits because they are ineligible for such benefits.

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.³⁰ 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.³¹ 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.³²

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 (see Figure 1).³³ For Medicaid specifically, studies found a 15-36% drop in enrollment during this period.³⁴ 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.³⁵

29 "Medi-Cal: The Details," Disability Benefits 101. Department of Homeland Security, "Inadmissibility."

30 Michael E. Fix and Jeffrey S. Passel, "Trends in Noncitizens' and Citizens' Use of Public Benefits Following Welfare Reform," Urban Institute (The Urban Institute, 1999), <https://www.urban.org/sites/default/files/publication/69781/408086-Trends-in-Noncitizens-and-Citizens-Use-of-Public-Benefits-Following-Welfare-Reform.pdf>. Michael Fix and Jeffrey Passel, "The Scope and Impact of Welfare Reform of Immigrant Provisions," Urban Institute, January 2002, <https://www.urban.org/sites/default/files/publication/60346/410412-Scope-and-Impact-of-Welfare-Reform-s-Immigrant-Provisions-The.PDF>.

31 Fix and Passel, "The Scope and Impact," 15.

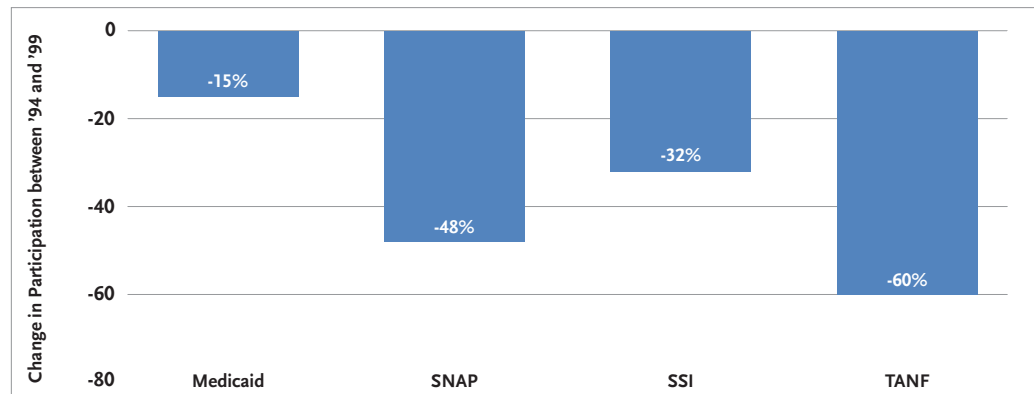
32 Pereira M Krista et al., "Barriers To Immigrants' Access To Health And Human Services Programs," (U.S. Department of Health and Human Services, May 25, 2012), <https://aspe.hhs.gov/immigrant-access-health-and-human-services>.

33 Fix and Passel, "Trends in Noncitizens' and Citizens'," 2. Fix and Passel, "Scope and Impact," 15. Namratha R. Kandula et al., "The Unintended Impact of Welfare Reform on the Medicaid Enrollment of Eligible Immigrants," The Canadian Journal of Chemical Engineering (Wiley-Blackwell, August 26, 2004), <http://onlinelibrary.wiley.com/doi/10.1111/j.1475-6773.2004.00301.x/abstract>.

34 Wendy Zimmerman and Michael E. Fix, *Declining Immigrant Applications for Medi-Cal and Welfare Benefits in Los Angeles County*, rep. (Urban Institute, July 1, 1998), <http://webarchive.urban.org/publications/407536.html>. Kandula et al., "The Unintended Impact." Fix and Passel, "Trends in Noncitizens' and Citizens'," 15, 19.

35 Tara Watson, "Enforcement and Immigrant Location Choice," (NBER, November 7, 2013), <https://www.nber.org/papers/w19626>. M. L. Berk and C. L. Schur, "The Effect of Fear on Access to Care among Undocumented Latino Immigrants," *Journal of Immigrant Health*, 2001, 3(3):151-56, <https://www.ncbi.nlm.nih.gov/pubmed/16228780>.

Figure 1. Change in Participation for Means-Tested Benefits Programs by Chilled Families from 1994 to 1999³⁶



Chilling Effects Today

As previously mentioned, the vast majority of those subject to public charge determinations are ineligible for public benefits. This is because legal permanent residency, a humanitarian visa, or citizenship are generally program eligibility requirements (see Appendix B for a list of public benefits programs and eligibility requirements).³⁷ Nonetheless, substantial numbers of lawfully present immigrants not subject to the benefits test are expected to curb their public benefits usage.³⁸ 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.³⁹

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.⁴⁰ In fact, the Protecting Immigrant Families campaign has worked diligently to educate service providers on encouraging panicked clients to stay enrolled in benefits.⁴¹ Given patterns of disenrollment following the welfare reform legislation passed in 1996, 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.⁴² 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.⁴³

³⁶ Fix and Passel, "The Scope and Impact," 15.

³⁷ Capps et al., "Gauging the Impact."

³⁸ Batalova, Fix, and Greenberg, "Chilling Effects."

³⁹ Michael E. Fix and Wendy Zimmermann, rep., *All Under One Roof: Mixed-Status Families in an Era of Reform* (Urban Institute, October 6, 1999), <http://webarchive.urban.org/UploadedPDF/409100.pdf>.

⁴⁰ Connie Choi (Protecting Immigrant Families Campaign Field Manager and Strategist, National Immigration Law Center), email message to author, January 18, 2019.
Katherine R Page and Sarah Polk, "Chilling Effect? Post-Election Health Care Use by Undocumented and Mixed-Status Families | NEJM," *New England Journal of Medicine*, last modified March 23, 2017, <https://www.nejm.org/doi/full/10.1056/NEJMp1700829>. doi:10.1056/nejmp1700829.

Samantha Artiga and Petry Ubri, "Living in an Immigrant Family in America: How Fear and Toxic Stress Are Affecting Daily Life, Well-Being, & Health - Issue Brief," (The Henry J. Kaiser Family Foundation, June 22, 2018), <https://www.kff.org/report-section/living-in-an-immigrant-family-in-america-issue-brief/>.

Samantha Artiga and Barbara Lyons, "Family Consequences of Detention/Deportation: Effects on Finances, Health, and Well-Being," (The Henry J. Kaiser Family Foundation, October 11, 2018), <https://www.kff.org/disparities-policy/issue-brief/family-consequences-of-detention-deportation-effects-on-finances-health-and-well-being/>.

⁴¹ Connie Choi (Protecting Immigrant Families Campaign Field Manager and Strategist, National Immigration Law Center), in discussion with an author, Los Angeles, CA, January 7, 2019.

⁴² Batalova, Fix, and Greenberg, "Chilling Effects."

⁴³ Department of Homeland Security, "Inadmissibility."

CHAPTER 3

PROJECTED CONSEQUENCES OF THE RULE CHANGE

In light of the public charge proposal's wide reach, the magnitude of consequences for immigrant families could be quite large. Despite prevailing legal advice, many immigrants wonder if future changes in the law will strip them of their green cards, reverse their citizenship, or lead to deportation that separates their families based on retroactive benefits.⁴⁴ Others misunderstand the current proposal and believe there will be negative repercussions based on their benefits use.⁴⁵ As a result of disenrolling in programs, already stressed low-income families who depend on public benefits would face increased food insecurity, housing instability, and unmet health needs.⁴⁶ At the end of this chapter, we summarize our findings (Figure 2) on the projected consequences of the proposed public charge expansion with respect to Medi-Cal.

Projected Disenrollment

Immigration experts have used different methodologies and datasets to provide a range of estimates of the chilled population, which are summarized in Appendix C. 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**.⁴⁷ 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.⁴⁸ 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.⁴⁹ Still, we chose to use CHPR's analysis because it is the only one focused on California thus far, and we expect that its definition excludes only a small number of people.⁵⁰

44 Per email correspondence with Connie Choi of NILC on February 21, 2019, immigration attorneys strongly advise clients to make decisions, such as continuing public benefits usage, based on current and proposed laws rather than possible laws that have yet to be proposed. Such future changes in immigration law are technically possible though highly improbable. Connie Choi (Protecting Immigrant Families Campaign Field Manager and Strategist, National Immigration Law Center), email message to the authors, February 21, 2019. Batalova, Fix, and Greenberg, "Chilling Effects," 30.

45 Connie Choi (Protecting Immigrant Families Campaign Field Manager and Strategist, National Immigration Law Center), email message to the authors, February 21, 2019.

46 Batalova, Fix, and Greenberg, "Chilling Effects," 31.

47 CHPR relies on data from the California Health Interview Survey (CHIS), one of the largest surveys of respondents living in California on health status, access to health coverage, immigration status, and other demographic characteristics. Center for Health Policy Research, "UCLA Center for Health Policy Research," Search Press Releases | UCLA Center for Health Policy Research, 2012, <http://healthpolicy.ucla.edu/chis/about/Pages/about.aspx>. Ninez A. Ponce, Laurel Lucia, and Tia Shimada, "Proposed Changes to Immigration Rules Would Cost California Jobs, Harm Public Health: Data Tables," (UCLA Center for Health Policy Research, December 4, 2018), Last Accessed: December 10, 2018, <http://healthpolicy.ucla.edu/publications/Documents/PDF/2018/PublicChargeDataTables.pdf>, 2.

48 Most LPRs with less than five years of residency in the United States are excluded. Specifically, CHPR counts the following Medi-Cal recipients as their chilled population: 1) LPRs present in the United States five or more years; 2) LPR children and pregnant women regardless of length of time in the United States; 3) citizen children with a noncitizen parent (including undocumented parents); 4) refugees and asylees; and 5) other noncitizens eligible for full-scope federally funded benefits. Ninez A. Ponce, Laura Lucia, and Tia Shimada, "Proposed Changes to Immigration Rules Could Cost California Jobs, Harm Public Health," (UCLA Center for Health Policy Research, December 4, 2018), <http://healthpolicy.ucla.edu/publications/Documents/PDF/2018/publiccharge-methods-dec2018.pdf>, 2.

49 Ponce, Lucia, and Shimada, "Proposed Changes," 2.

50 Ninez A. Ponce, Laurel Lucia, and Tia Shimada, "How Proposed Changes to the 'Public Charge' Rule Will Affect Health, Hunger and the Economy in California," *The Center's 2018 Health Policy Seminar Series*, (lecture, November 7, 2018), <https://healthpolicy.ucla.edu/newsroom/Documents/2018/public-charge-seminar-slides-nov2018.pdf>, 14.

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 E).⁵¹ "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 was in 1996.⁵² 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.⁵³ Conversely, Medi-Cal disenrollment could lead to increased adult mortality. If losing Medi-Cal coverage has a similar effect size 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.⁵⁴

Many additional health benefits can be attributed to Medicaid coverage. A major randomized control trial of the 2008 Medicaid expansion in Oregon showed that gaining Medicaid resulted in reduced rates of depression, increased rates of diabetes detection and management, and increased self-rated health.⁵⁵ We expect the opposite to occur with the loss of Medi-Cal coverage. Additionally, anti-immigration policies are associated with increased rates of preterm births, delayed and decreased prenatal care, depression, anxiety, and post-traumatic stress disorder.⁵⁶ Disenrollment due to the public charge rule change thus takes away protective measures against these health concerns as immigrant families combat stress. Finally, children who are chronically uninsured or who have gaps in public or private health insurance not only have lower rates of vaccinations and annual exams, they experience more activity limitations (e.g., missed school, inability to play, etc.) as a result of illness compared to children with consistent insurance coverage.⁵⁷

51 Estimates are rounded to the nearest thousand. Ponce, Lucia, and Shimada, "Proposed Changes: Data Tables," 4.

52 Steve Wallace (professor, UCLA), in discussion with an author, Los Angeles, CA, December, 20, 2018. Connie Choi (Protecting Immigrant Families Campaign Field Manager and Strategist, National Immigration Law Center), in discussion with an author, Los Angeles, CA, January 7, 2019. Almas Sayeed (Deputy Director of Programs, California Immigrant Policy Center), in discussion with an author, Los Angeles, CA, January 10, 2019.

53 Benjamin D. Sommers et al., "Health Insurance Coverage and Health — What the Recent Evidence Tells Us," *New England Journal of Medicine* 377, no. 6 (August 10, 2017): 586–93, doi:10.1056/nejmsb1706645.

54 Notably, the 274,000 adults includes elderly adults, whereas the "number needed to treat/harm" is derived from studies on non-elderly adults. We are unable to determine which of the 693,000 adults are non-elderly based on publicly available data and thus encourage caution with our mortality estimate. Additionally, the Medicaid expansion studies were conducted over 4-5 years, so this increase in mortality from loss of Medi-Cal coverage may not be seen immediately. Ponce, Lucia, and Shimada, "Proposed Changes," Lecture, 31.

55 Unlike the other Medicaid expansion studies cited previously for the mortality estimate, this study did not make any claims about the number needed to gain Medicaid coverage to see a unit of change for any of the health effects described. Thus, we cannot make a quantifiable prediction of how much depression, diabetes detection and management, or self-rated health might change with anticipated disenrollment.

Katherine Baicker et al., "The Oregon Experiment — Effects of Medicaid on Clinical Outcomes," *New England Journal of Medicine* 368, no. 18 (May 2, 2013): pp. 1713-1722, <https://doi.org/10.1056/nejmsa1212321>.

56 Omar Martinez et al., "Evaluating the Impact of Immigration Policies on Health Status Among Undocumented Immigrants: A Systematic Review." *Journal of Immigrant and Minority Health* 17, no. 3 (June 2015): pp.947–70. doi:10.1007/s10903-013-9968-4.

57 Lynn M. Olson, Suk-Fong S. Tang, and Paul W. Newacheck, "Children in the United States with Discontinuous Health Insurance Coverage," *New England Journal of Medicine* 353, no. 4 (2005): pp. 382-391, <https://doi.org/10.1056/nejmsa043878>.

Judith R. Lave, "Impact of a Children's Health Insurance Program on Newly Enrolled Children," *Jama* 279, no. 22 (1998): p. 1820, <https://doi.org/10.1001/jama.279.22.1820>.

Paul W. Newacheck et al. "Health Insurance and Access to Primary Care for Children," *New England Journal of Medicine* 338, no. 8 (1998): pp. 513-519, <https://doi.org/10.1056/nejm199802193380806>.

Roughly 1,480,000 mostly native-born children in California have at least one undocumented parent.⁵⁸ These children live in heightened fear of losing that parent to deportation every time immigration enforcement increases.⁵⁹ A growing body of evidence has shown that childhood stressors such as these, termed “toxic stress,” have significant adverse health effects lasting into adulthood, such as increasing the risk of heart disease and diabetes.⁶⁰ Thus, these children could experience long-term health consequences as a result of the toxic stress induced by the public charge rule change even if they stay enrolled in Medi-Cal.

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.⁶¹ 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.⁶² By losing Medi-Cal, many chilled people will be forced to pay out-of-pocket for medical expenses.⁶³ 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.⁶⁴ Furthermore, individuals in the chilled population may skip doctor visits and delay care because of high medical costs.⁶⁵ 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.⁶⁶

In addition to individual financial burdens, lost federal funding due to Medi-Cal disenrollment would have negative ripple effects across California’s economy.⁶⁷ 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.⁶⁸ Under this lower disenrollment scenario, we predict that California will lose \$510 million in federal Medi-Cal funding that would have gone to hospitals, medical laboratories, insurance providers, and other health care entities.⁶⁹ 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

58 Artiga and Ubri, “Living in an Immigrant Family.”

59 Ibid.

60 Jack P. Shonkoff and Andrew S. Garner, “The Lifelong Effects of Early Childhood Adversity and Toxic Stress,” *Pediatrics* 129, no. 1 (January 2012): e232–e246. doi:10.1542/peds.2011-2663.

61 Ponce, Lucia, and Shimada, “Proposed Changes,” 1-3.

62 Leighton Ku, *Why Immigrants Lack Adequate Access to Health Care and Health Insurance*, rep., (Migration Policy Institute, September 1, 2006), <https://www.migrationpolicy.org/article/why-immigrants-lack-adequate-access-health-care-and-health-insurance>.

63 Teresa E Coughlin et al., *Uncompensated Care for the Uninsured in 2013: A Detailed Examination*, rep., (The Urban Institute, May 30, 2014), <https://www.kff.org/uninsured/report/uncompensated-care-for-the-uninsured-in-2013-a-detailed-examination/>. Centers for Medicare & Medicaid Services, “Cost Sharing Out of Pocket Costs,” [Medicaid.gov](https://www.medicare.gov), accessed February 12, 2019, <https://www.medicare.gov/medicaid/cost-sharing/out-of-pocket-costs/index.html>.

64 Centers for Medicare & Medicaid Services, “Cost Sharing.” David U Himmelstein et al., *Illness And Injury As Contributors To Bankruptcy*, rep., (Project HOPE—The People-to-People Health Foundation, Inc., October 6, 2017), <https://www.healthaffairs.org/doi/pdf/10.1377/hlthaff.W5.63>, 63. Barbara Kate Repa, “If Your Wages Are Garnished: Your Rights,” www.nolo.com (Nolo, February 22, 2014), <https://www.nolo.com/legal-encyclopedia/if-wages-are-garnished-rights-33050.html>. Katherine Baicker et al., “The Oregon Experiment.”

65 Himmelstein et al., *Illness And Injury*, 68.

66 Alex Wang, Jeffrey Hayes, and Liz Ben-Ishai, *As Foreign-Born Worker Population Grows, Many Lack Paid Sick Days*, rep. (CLASP, Institute for Women’s Policy Research, July 2014), <https://www.clasp.org/sites/default/files/public/resources-and-publications/publication-1/Paid-Sick-Days-Immigrants-CLASP-IWPR.pdf>, 1-2.

67 CHPR’s analysis focuses on lost federal dollars as these funds are both predictable and come from outside California’s economy. They do not measure impacts to the economy that are difficult to estimate, such as diminished productivity of workers for losing health insurance, increases in bankruptcy, or impacts on the federal deficit. Finally, their economic impact estimates are made using IMPLAN, a widely used economic modeling software. Ponce, Lucia, and Shimada, “Proposed Changes,” 3-4.

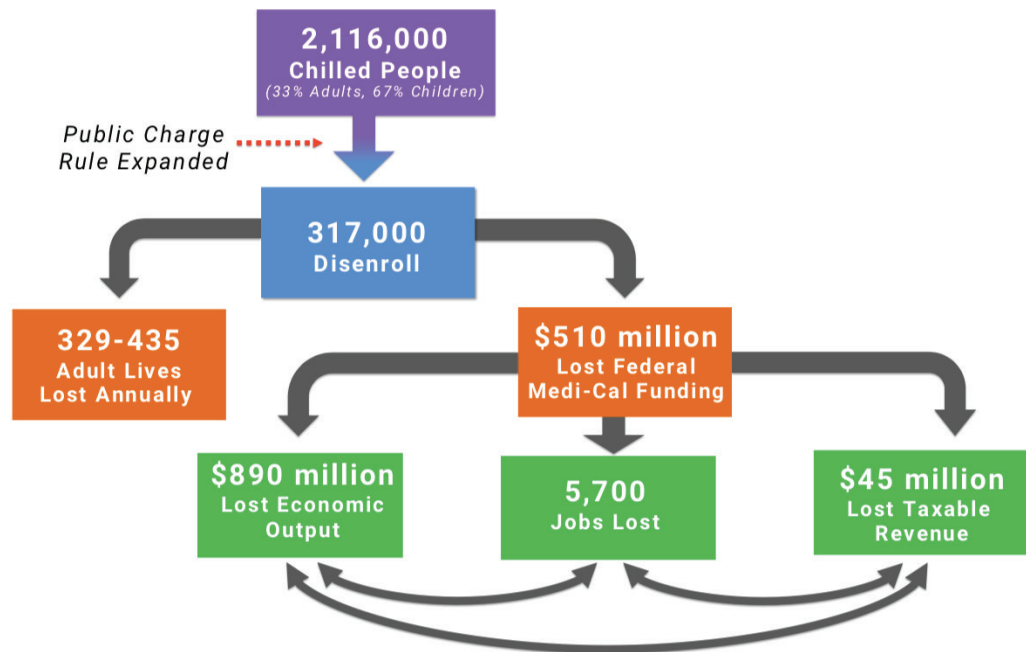
68 This adjustment method was recommended by the study authors. For example, CHPR predicts a loss of 13,200 jobs at 35% disenrollment: $13,200 * 15/35 = 5,657$ at 15% disenrollment. Laurel Lucia (Director, Health Care Program, UC Berkeley Labor Center), email message to an author, January 18, 2019.

69 To calculate loss of federal funding, CHPR multiplies the number of expected disenrollees by the average per person spending received from the federal government for Medi-Cal. Ponce, Lucia, and Shimada, “Proposed Changes,” 3. Ponce, Lucia, and Shimada, “Proposed Changes: Data Tables,” 5-6.

million in taxable revenue (for regional level estimates, see Appendix E).⁷⁰ CHPR expects 68% of these job losses to occur in the health care, real estate, and food industries.⁷¹

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.⁷² This cost would then become the responsibility of health care systems, especially non-profit hospitals, which generally absorb unreimbursed costs when uninsurance rates rise.⁷³ Of course, 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.

Figure 2. Projected Consequences of 15% Disenrollment by the Chilled Population⁷⁴



⁷⁰ We round to the nearest hundred people for job loss and to the nearest million for other economic estimates in accordance with CHPR's rounding.

Ponce, Lucia, and Shimada, "Proposed Changes," Lecture, 36, 39-40.

⁷¹ Ibid., 37.

⁷² Coughlin, Holahan, Caswell, and McGrath, *Uncompensated Care*. Fiscal Policy Institute, *Only Wealthy Immigrants Need Apply: How a Trump Rule's Chilling Effect Will Harm the U.S.*, rep., October 10, 2018, <http://fiscalspolicy.org/wp-content/uploads/2018/10/US-Impact-of-Public-Charge.pdf>.

⁷³ Drew Calvert, "Who Bears the Cost of the Uninsured? Nonprofit Hospitals," rep. (Kellogg School of Management at Northwestern University, June 22, 2015), <https://insight.kellogg.northwestern.edu/article/who-bears-the-cost-of-the-uninsured-nonprofit-hospitals>.

⁷⁴ Sommers et al., "Health Insurance Coverage and Health." Benjamin D. Sommers, "State Medicaid Expansions and Mortality, Revisited: A Cost-Benefit Analysis," *American Journal of Health Economics* 3, no. 3 (2017): pp. 392-421, https://doi.org/10.1162/ajhe_a_00080.

Ponce, Lucia, and Shimada, "Proposed Changes: Data Tables," 5.

Ponce, Lucia, and Shimada, "How Proposed Changes," 37, 39-40.

CHAPTER 4

METHODOLOGY FOR GENERATING AND EVALUATING POLICY OPTIONS

Sources of Data

To generate policy options that could mitigate the adverse effects of Medi-Cal disenrollment, we reviewed publicly available research on public charge, beginning with work that was frequently cited by leading immigration researchers. We used a snowballing approach for our literature review, in which additional pertinent literature and news articles were found in the reference lists of articles, to identify the underlying factors likely to affect Medi-Cal participation and disenrollment behaviors of the chilled population, as well as to identify potential mitigating solutions.⁷⁵

Building on this research, we conducted semi-structured interviews with a wide range of academics, advocates, attorneys, and policymakers at the county and state level to identify additional policy alternatives.⁷⁶ To yield the broadest range of plausible options, we selected informants in consultation with our client to maximize the diversity in expertise.⁷⁷ We also assured confidentiality to our informants in order to encourage them to share potentially controversial or personal opinions. Subsequently, we have left out identifying details throughout the report unless explicit permission was otherwise granted.

We asked all informants about their thoughts on (1) the potential impact of the proposed expansion to the public charge rule, (2) potential strategies for keeping the chilled population insured, (3) political feasibility of these strategies, and (4) the people or institutions that might have the power and/or political will to implement these strategies (see Appendix F for a list of interview questions). After completing 10 informant interviews, we reached a saturation point when no new ideas emerged. Therefore, we stopped seeking additional interviews. We also contacted eight additional informants with similar expertise to answer specific questions via email about policies under consideration.

We invited 16 of our informants to participate in a short online political feasibility survey on the final policy alternatives; 11 responded.⁷⁸ The first part of the survey asked participants to score political feasibility for each alternative on a four-point Likert scale.⁷⁹ The second part asked participants to rank-order all policy options against each other, assuming a cost of \$20 million per

75 Trisha Greenhalgh and Richard Peacock, "Effectiveness and Efficiency of Search Methods in Systematic Reviews of Complex Evidence: Audit of Primary Sources," *Bmj* 331, no. 7524 (2005): pp. 1064-1065, <https://doi.org/10.1136/bmj.38636.593461.68>.

76 Three additional informants were contacted for interviews but were unavailable.

77 The academics were affiliated with the University of California, Los Angeles or the University of Southern California and had expertise in immigration, immigrant health, health care, and/or labor and employment issues. The advocates all worked for locally or nationally prominent immigrant advocacy organizations. The policymakers represented a variety of political views, departments, and roles within county and state levels of government, and all worked extensively with immigrant communities.

78 Two informants were not invited to participate in the survey because we contacted them after the survey had already been administered.

79 We calculated the average score and standard deviation for each policy option by using responses from the first part of the survey. We also calculated the percent of respondents who felt each policy was feasible (i.e., what percent of respondents voted "3" or "4" for each policy).

year (for the full survey, see Appendix G).⁸⁰ This allowed for political feasibility comparisons to not be influenced by cost. We included the rank ordering to help differentiate the viability of alternatives in the event that respondents scored all policy options similarly on the Likert scale.⁸¹

Finally, we analyzed 2015-2017 California Health Interview Survey (CHIS) data obtained using AskCHIS to derive population estimates for our policy evaluations. AskCHIS is an online query tool that displays publicly available information from the same confidential CHIS database used by the Center for Health Policy Research in its public charge research (see Appendix H for variables used in our estimates).⁸²

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 (discussed further in Chapter 5). We evaluated policy alternatives based on their (1) efficacy, (2) cost of implementation, (3) cost-effectiveness ratio, and (4) political feasibility.⁸³ In addition to the California Immigrant Policy Center's (CIPC's) desire to know which policies might have the most significant impact (i.e., efficacy), we measure cost and cost-effectiveness to provide our client with an analysis that would be helpful when there are known budget constraints. Finally, we assess political feasibility to help CIPC consider how difficult lobbying might be and what factors would need to change to make policy alternatives more politically viable. We define our criteria as follows:

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. Practically speaking, we calculate the number of chilled people who would not relinquish their Medi-Cal benefits and those who would newly enroll in Medi-Cal as a result of the policy. Because all the economic and health impacts described in Chapter 3 are directly related to decreased Medi-Cal enrollment, the most efficacious policy options should also produce the most significant economic and health benefits. We discuss predicted changes to these economic and health impacts following our policy recommendation.

Cost of implementation is the total identifiable direct costs to government at the state- and county-level. When we cannot quantify certain factors (e.g., administrative costs), we describe those narratively instead. We do not include the cost of downstream economic impacts (e.g., lost jobs and economic output) as those are a direct result of enrollment, which is already included in our estimate of efficacy. Additionally, we include costs for increased state spending on new Medi-Cal beneficiaries who were previously uninsured but exclude costs related to improved renewal rates of existing Medi-Cal beneficiaries. . This is consistent with the state legislature's cost-calculating methodologies of previous Medi-Cal bills.⁸⁴ The cost criterion is essential in making decisions when strict budget limitations exist, making some policy options entirely impossible.

80 This cost estimate was selected to help anchor respondents to a shared scenario that we believed to be realistic based on information available to us at the time. The goal was to help prevent respondents from evaluating a policy as particularly feasible or infeasible based on different imagined costs.

81 For the second part (rank ordering), we assigned options three points for each vote of most feasible, two points for each vote of medium feasibility, and one point for least feasible. We compared the total points for each option within the ranking question to devise an overall ranking.

82 Ponce, Lucia, and Shimada, "Proposed Changes," Lecture, 15.

83 We considered organizational feasibility as a criterion, but CIPC preferred that we not limit our analysis to policies based on the scope of their current resources and priorities. We also considered equity as a criterion, which we defined as increasing the "group-based distribution" of benefits to disadvantaged people. However, we could not determine how different populations would respond to various policy options and thus could not compare equity.

84 Centers for Medicare and Medicaid Services, "Medicaid Program; Mechanized Claims Processing and Information Retrieval Systems (90/10)," Federal Register 80, no. 75817 (December 4, 2015): 75817-75843, <https://www.federalregister.gov/documents/2015/12/04/2015-30591/medicaid-program-mechanized-claims-processing-and-information-retrieval-systems-9010>. "Assembly Bill 2579," Bill Text - AB-2579 Medi-Cal: Special Supplemental Nutrition Program for Women, Infant, and Children, 2018, https://leginfo.ca.gov/faces/billAnalysisClient.xhtml?bill_id=201720180AB2579.

Cost-effectiveness ratio is the projected cost divided by projected efficacy (i.e., dollars per person diverted from disenrollment). Thus, a policy option with a numerically lower cost-effectiveness ratio has “greater cost-effectiveness” than one with a numerically higher cost-effectiveness ratio. All else being equal, policy options with greater cost-effectiveness are preferable as they provide “more bang for the buck.” This criterion is useful in evaluating policies when the amount of money is fixed or is equivalent between options.

Political feasibility is a policy option’s likelihood of being passed into law given California’s current political climate.⁸⁵ 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.⁸⁶ We base these rankings on evidence from our political feasibility survey, as well as news articles and informant interviews on the current political climate and historical contentiousness of similar policies. Because all policy alternatives generated are state-level interventions, we describe these components at the state-level and incorporate county-level political context when relevant.

Policy Evaluation Method

We gave priority to efficacy as the most important criterion in evaluating our policy options because CIPC’s goal is to maximize benefits for immigrant families. We did not recommend policies with low political feasibility as they are unlikely to pass in the current political context. Because we do not have insights into state or county budget maximums or CIPC’s lobbying resources, we describe the tradeoffs for cost, cost-effectiveness ratio, and political feasibility among policy alternatives rather than weighing these factors against efficacy. In summary, 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 that is politically viable with the least tradeoff in cost, cost-effectiveness, and political feasibility.

Given the nature of two-year legislative election cycles in California, it would be difficult to make meaningful predictions of political viability beyond the end of 2020. Thus, we limit our evaluation of political feasibility over a roughly two-year time frame when the current state legislature and governorship are set.⁸⁷ Additionally, costs are likely to be greatest in the first years of the policy options we evaluate given generally higher implementation costs compared to maintenance costs. Finally, significant disenrollment occurred within the first three years of the last public charge rule update, so interventions need to occur soon after the public charge rule is finalized to best mitigate disenrollment.⁸⁸

⁸⁵ We define “current” as a two-year time frame and further discuss this distinction in the Evaluation Method of this chapter.

⁸⁶ John W. Kingdon, “The Policy Window, and Joining the Streams,” chapter, in *Agendas, Alternatives, and Public Policies*, Second (New York, NY: HarperCollins College Publishers, 1995), pp. 168-69, 173-75.

⁸⁷ Kingdon, “The Policy Window,” 168-69, 173-75.

⁸⁸ Fix and Passel, “Trends in Noncitizens’ and Citizens’.”

Kandula et al., “The Unintended Impact.”

Zimmerman and Fix, *Declining Immigrant Applications for Medi-Cal*.

CHAPTER 5

POLICY OPTIONS TO MAXIMIZE MEDI-CAL ENROLLMENT

Policy Alternatives Considered

The California Immigrant Policy Center (CIPC), in collaboration with the Protecting Immigrant Families campaign and other partners, plans to pursue litigation once the U.S. Department of Homeland Security finalizes the rule, and in the meantime, have continued educating service providers about the public charge provision.⁸⁹ Thus, we sought out policy alternatives that would complement these efforts and address the health impacts of uninsurance and economic impacts of lost federal Medi-Cal funding. Through lessons drawn from the extant literature and the interviews with knowledgeable informants, we generated 25 policy options that could plausibly improve Medi-Cal participation or provide other forms of health coverage for the chilled population (listed in Appendix I).

We discarded three options that provided health care or insurance outside of Medi-Cal because each came with a loss of federal Medi-Cal funding while increasing costs for state and county governments. Eight additional options focused on improving household wealth and reducing reliance on public benefits through poverty reduction, labor development, encouraging union participation, and improving employee protections. We chose not to analyze these options as some would not have reduced poverty enough to make private health insurance affordable. For other options, we could not identify enough evidence to predict how Medi-Cal participation would change.

The remaining options addressed reasons why chilled people disenroll or are uninsured. Those who are uninsured yet Medi-Cal eligible typically suffer from “uptake” or “retention” issues.⁹⁰ Two of the most common *uptake* issues that prevent new enrollments are difficulty with the complicated *enrollment* process or an incorrect belief that one is ineligible; similarly, difficulty with complicated *renewal* processes is one of the most common *retention* problems.⁹¹ In fact, some lawmakers have historically taken advantage of this complexity by increasing the frequency of renewals to reduce enrollment with the goal of controlling state budgets in the short-term.⁹²

For the chilled population, decision making around enrollment and renewals is not just a matter of weighing burdensome paperwork against the benefit of health insurance as it may be for other low-income individuals. Chilled people must also consider how benefits might affect their immigration status. The incorrect belief that benefits use may result in immigration

89 Connie Choi (Protecting Immigrant Families Campaign Field Manager and Strategist, National Immigration Law Center), in discussion with an author, Los Angeles, CA, January 7, 2019.

90 Benjamin D. Sommers, “Why Millions Of Children Eligible For Medicaid And SCHIP Are Uninsured: Poor Benjamin D. Sommers, “Loss of Health Insurance Among Non-Elderly Adults in Medicaid,” *Journal of General Internal Medicine* 24, no. 1 (2008): 1-7, <https://doi.org/10.1007/s11606-008-0792-9>.

Genevieve M. Kenney et al. “Children Eligible for Medicaid or CHIP: Who Remains Uninsured, and Why?,” *Academic Pediatrics* 15, no. 3 (2015), <https://doi.org/10.1016/j.acap.2015.01.009>.

91 Sommers, “Loss of Health Insurance,” 1-7.
Kenney et al. “Children Eligible for Medicaid or CHIP.”

92 Donna Cohen Ross and Laura Cox, *Beneath the Surface: Barriers Threaten to Slow Progress on Expanding Health Coverage of Children and Families: A 50 State Update on Eligibility, Enrollment, Renewal and Cost-Sharing Practices in Medicaid and SCHIP*, rep. (The Henry J. Kaiser Family Foundation, October 2004), <https://www.cbpp.org/archiveSite/10-4-04health.pdf>, 2, 6-7.

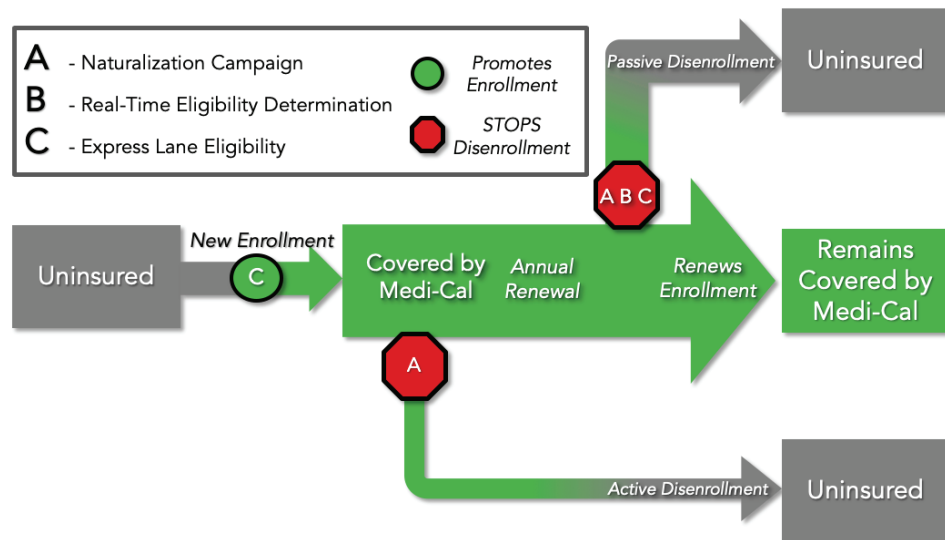
sanctions could cause chilled people to *passively disenroll* by letting coverage lapse at annual renewal periods (i.e., not submitting renewal paperwork), or *actively disenroll* prior to renewal (i.e., contacting a benefits office).⁹³ Thus, maximizing Medi-Cal participation by the chilled population can be best achieved by decreasing fear around benefits usage, supporting new enrollment, and encouraging renewals.

Of the 14 options addressing these intervention points, we did not analyze 11 because of a lack of data with which to make efficacy and cost predictions. Five of these options aimed to reduce fear: legal or technical data-sharing barriers between clinics and the federal government (e.g., firewalls or a prohibition against sharing a community clinic’s HIPAA protected information with the federal government), penalties for “notarios” who pose as lawyers and provide incorrect advice, educating immigrant families (via community workers, ethnic media, a hotline, and schools), patient identification cards for use in clinics that are not linked to legal identities, and targeted voter registration and engagement to elect more immigrant-friendly leaders.⁹⁴ The remaining six policy options focused on uptake and retention: targeted enrollment campaigns, reducing reading levels required to understand enrollment materials, pre-completed renewal forms that only require signatures for consent, making disenrollment difficult (like online subscription services), enrolling children in Medi-Cal/Children’s Health Insurance Program (CHIP) for five years upon signup instead of one year, and a new joint enrollment and renewal process for Medi-Cal combining state and county systems.

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) a naturalization campaign, (2) real-time eligibility determination (RTED), and (3) Express Lane Eligibility (ELE). We show how these policy options address the reasons why chilled people may disenroll or be uninsured in Figure 3. 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 3. Model of why chilled people are uninsured and how to intervene



93 Though no studies have addressed whether passive or active disenrollment is more common for chilled families, one interview informant felt that passive disenrollment was the more likely mechanism.

94 Legally, notarios can only provide notary services. However, many Latino immigrants use them as cheaper sources of legal advice because some illegally advertise themselves as lawyers. Also noteworthy, to avoid worrying those who had not yet heard of the public charge proposal, PIF coalition leaders chose not to educate immigrant families on the issue, and instead focused on educating service providers.

Connie Choi (Protecting Immigrant Families Campaign Field Manager and Strategist, National Immigration Law Center), in discussion with an author, Los Angeles, CA, January 7, 2019.

1. Naturalization Campaign: Reducing Fear

Following the enactment of welfare reform with the Personal Responsibility and Work Opportunity Reconciliation Act of 1996, naturalized citizens remained enrolled in public benefits at the same rates as native-born citizens.⁹⁵ This could have occurred because naturalized citizens felt more secure about their immigration status than green card holders and did not fear immigration consequences when using public benefits.⁹⁶ Thus, supporting more legal permanent residents (LPRs) on a pathway to obtaining citizenship could be one way of reducing fear, leading them and their dependents to stay enrolled in Medi-Cal.

All LPR adults who have lived in the United States for at least five years and are in good moral standing are eligible to naturalize.⁹⁷ In California, there are currently an estimated 2,200,000 adults who are “eligible to naturalize” (ETNs), but many do not know of their eligibility.⁹⁸ The high cost of applications (\$725) can be a significant barrier for poor immigrants as many are unaware that they can receive application fee waivers by having an income less than 150% of the Federal Poverty Level or by being enrolled in a means-tested benefits program like Medicaid.⁹⁹

Additionally, a large randomized control trial in New York City found that informing ETNs that they were eligible for application fee waivers improved naturalization rates by 35%.¹⁰⁰ A second part of the same trial found that fee vouchers doubled the naturalization rate for low-income individuals whose incomes were just above the fee waiver eligibility threshold.¹⁰¹ Although all study participants had voluntarily signed up to receive information about naturalization and thus were motivated to apply, these findings suggest that educating ETNs about financial resources for naturalization, including fee waivers, may significantly improve their likelihood of applying for citizenship.¹⁰²

Since Fiscal Year (FY) 2015-2016, the state of California has funded immigrant support services through the One California program, including providing funding for contractors who provide naturalization services.¹⁰³ For FY 2019-2020, Governor Newsom has elected to continue providing \$65 million in immigration services funding, a third of which has historically supported naturalization efforts by local, direct service providers.¹⁰⁴ Our naturalization policy option would: establish and fund a new statewide naturalization program within One California that would (1) notify residents of their eligibility to naturalize and receive application fee

95 Fix and Passel, “Trends in Noncitizens’ and Citizens’.”

96 Miriam Jordan, “Wait Times for Citizenship Have Doubled in the Last Two Years,” *The New York Times*, February 21, 2019, <https://www.nytimes.com/2019/02/21/us/immigrant-citizenship-naturalization.html?smid=nytcore-ios-share>.

97 U.S. Citizenship and Immigration Services, “Naturalization Information,” 23.11 Cuban Adjustment Act Cases. | USCIS, 2019, <https://www.uscis.gov/citizenship/educators/naturalization-information>.

98 USC Center for the Study of Immigrant Integration and Sabrina Kim, *Interactive Map: Eligible to Naturalize Adults by Probability of Naturalization - by State*, map, *USC Dornsife*, accessed February 7, 2019, <https://dornsife.usc.edu/csii/map-eligible-to-naturalize-state>.

99 USC, *Interactive Map*.

Jens Hainmueller et al., “A Randomized Controlled Design Reveals Barriers to Citizenship for Low-Income Immigrants,” *Proceedings of the National Academy of Sciences of the United States of America* 115, no. 5 (2018): pp. 940, <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5798346/>.

Ricardo Ramirez, Olga Medina, *Catalysts and Barriers to Attaining Citizenship: An Analysis of ya es hora ¡CIUDADANIA!* Rep. (National Council of La Raza, 2010), <http://publications.unidosus.org/bitstream/handle/123456789/1145/catalystsandbarrierstoattainingcitizenship.pdf>.

Manuel Pastor et al., *Nurturing Naturalization: Could Lowering the Fee Help?* Rep. (Center for the Study of Immigrant Integration, University of Southern California, 2013), https://dornsife.usc.edu/assets/sites/731/docs/Nurturing_Naturalization_final_web.pdf.

U.S. Citizenship and Immigration Services, “Additional Information on Filing a Fee Waiver,” 23.11 Cuban Adjustment Act Cases. | USCIS, 2019, <https://www.uscis.gov/feewaiver>.

U.S. Citizenship and Immigration Services, “N-400 Application for Naturalization,” 23.11 Cuban Adjustment Act Cases. | USCIS, 2019, <https://www.uscis.gov/n-400>.

100 Michael Hotard et al., “A Low-Cost Information Nudge Increases Citizenship Application Rates Among Low-Income Immigrants,” *Nature Human Behavior*, 2397-3374 (April 15, 2019), <https://doi.org/10.1038/s41562-019-0572-z>.

101 Hainmueller et al., “Randomized Controlled Design.”

102 Hotard et al., “Nudge Increases Citizenship Application Rates.”
Hainmueller et al., “Randomized Controlled Design.”

103 California Immigrant Policy Center, “One California: Immigrant Services Funding,” California Immigrant Policy Center | Home, accessed February 9, 2019, <https://www.caimmigrant.org/what-we-do/immigrant-integration/one-california-immigrant-services-funding/>.

104 California Department of Social Services, “Immigration Services Funding Fact Sheet,” May 2018, http://www.cdss.ca.gov/Portals/9/Immigration/ISF_Fact_Sheet_May_2018.pdf?ver=2018-05-11-135436-710.

Governor’s Office, *2019-20 Governor’s Budget: Health and Human Services*, accessed February 15, 2019, <http://www.ebudget.ca.gov/2019-20/pdf/GovernorsBudget/4000/5180.pdf>.

waivers based on information in state Medi-Cal databases, (2) coordinate efforts among direct service providers, and (3) advertise the availability of naturalization services broadly. Based on the New York City study previously described, the key components to increasing naturalization rates in this campaign would be notifying ETNs of their fee waiver eligibility and connecting them to immigration services providers who could assist them with applications.¹⁰⁵

Because naturalized citizens use benefits in nearly identical ways to native-born citizens, we assume that the fear of deportation due to using benefits will dissipate when ETNs apply for naturalization.¹⁰⁶ Service providers can also reassure ETNs about their benefits usage when submitting naturalization applications.¹⁰⁷ Following this logic, we assume that ETNs who submit naturalization paperwork through One California will stay enrolled in Medi-Cal much like individuals who are already naturalized, even if their application is not yet approved.

2. Real-Time Eligibility Determination: Retention

As previously described, confusion around the enrollment and renewal process contributes significantly to uninsurance. There is broad consensus among researchers and advocates that simplifying the enrollment and renewal process encourages new signups and helps keep many people enrolled continuously, while also saving on administrative costs.¹⁰⁸ In fact, the Affordable Care Act (ACA) required states to start using real-time eligibility determination (RTED), a way of checking eligibility in 10-15 seconds, to streamline their Medicaid enrollment and renewal processes.¹⁰⁹ This is made possible by the Federal Hub, an electronic data clearinghouse that connects with multiple databases to quickly verify applicant-provided information.¹¹⁰ Multiple states have successfully updated their systems with impressive effects on enrollment and renewals, but California's results have not been as noteworthy due to a continued reliance on an outdated system that lacks RTED (discussed further in Chapter 6).¹¹¹

Automating Medi-Cal renewals, in effect, makes this an opt-out system once a user is enrolled. Extensive literature in behavioral economics and other fields has consistently shown that participation rates in organ donation, retirement savings accounts, email marketing schemes, and other programs are significantly higher with opt-out policies (instead of opt-in).¹¹² This is because people are more likely to choose the status quo option unless there is significant pressure or value in choosing otherwise.¹¹³ Under the current opt-in Medi-Cal renewal system, *passive* disenrollment by not submitting paperwork at renewal periods is the status quo option (*active* disenrollment requires calling benefits offices, which would not be considered the status quo). For beneficiaries on auto-renewal systems with RTED, participa-

105 Hotard et al., "Nudge Increases Citizenship Application Rates."
Hainmueller et al. "Randomized Controlled Design," 939-44.

106 Fix and Passel, "Trends in Noncitizens and Citizens"
Batalova, Fix, and Greenberg, "Chilling Effects."

107 We assume that even though some applications will be denied, these individuals will stay enrolled in public benefits anyway because they will have received counseling from a credible source during the application process.

108 Sommers, "Loss of Health Insurance."
Kenney et al. "Children Eligible for Medicaid or CHIP"

109 Jane Wishner et al., "Medicaid Real-Time Eligibility Determinations and Automated Renewals: Lessons for Medi-Cal from Colorado and Washington," rep., (Urban Policy Institute, August 2018), https://www.urban.org/research/publication/medicaid-real-time-eligibility-determinations-and-automated-renewals/view/full_report, 1, 36.

110 Wishner et al., "Medicaid Real-Time," 3.

111 Ibid., v.

112 William Samuelson and Richard Zeckhauser, "Status Quo Bias in Decision Making. *Journal of Risk & Uncertainty*," essay, in *Nudge: Improving Decisions about Health, Wealth, and Happiness* (London: Penguin, 2009), pp. 7-59.
Shai Davidai, Thomas Gilovich, and Lee D. Ross, *The Meaning of Default Options for Potential Organ Donors*, rep. (Proceedings of the National Academy of Sciences of the United States of America, September 18, 2012), <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3458339/>.
Steven Bellman, Eric J Johnson, and Gerald L Lohse, *To Opt In or To Opt Out: It Depends on the Question* (New York, New York: Columbia University, 2000), 1-8.
J Aysola et al., *A Randomized Controlled Trial of Opt-In Versus Opt-Out Enrollment Into a Diabetes Behavioral Intervention*, rep. (American Journal of Health Promotion, October 21, 2016), <https://www.ncbi.nlm.nih.gov/pubmed/28281353>.
Richard H Thaler and Cass R Sunstein, *Nudge: Improving Decisions About Health, Wealth and Happiness* (New Haven, CT: Yale University Press, 2008), <https://www.researchgate.net/file.PostFileLoader.html?id=53abe564cf57d7df1e8b45f4&assetKey=AS:273548994646025@1442230571326>, 109.

113 Samuelson & Zeckhauser, "Status Quo Bias in Decision Making."

tion rates are improved by making continued enrollment the easier, default option.¹¹⁴ Thus, RTED helps maintain coverage for chilled people who would have disenrolled passively.¹¹⁵ A simplified enrollment system with RTED should also make it easier for uninsured immigrant families to sign up for new coverage, representing a second way to improve enrollment.¹¹⁶ However, this path would be unlikely to significantly increase uptake without advertising the newly improved system to potential enrollees.¹¹⁷

Currently, RTED is available for people who enroll in Medi-Cal through the Covered California website, which uses a statewide system called the California Healthcare Eligibility, Enrollment and Retention System (CalHEERS).¹¹⁸ However, 79% of applicants apply through one of three county-based systems (called Statewide Automated Welfare Systems, or SAWS) that have limited RTED capabilities for new enrollments.¹¹⁹ Regardless of whether an individual has applied for Medi-Cal through the county or online through the state, the county processes all renewals and can only approve 40-60% of these automatically through verifying enrollees' qualifications by connecting to the Federal Hub.¹²⁰

This policy option would require counties to increase RTED for enrollments and auto-renewals through one of two mechanisms: (1) a greater reliance on CalHEERS by county benefits offices or (2) upgrading SAWS to have RTED capabilities. The first mechanism would require county offices to process all Medi-Cal applications through CalHEERS and separately process applications for other benefits programs through SAWS. The second mechanism would involve technical improvements to allow SAWS to provide RTED. Both mechanisms target the 79% of individuals who sign up for Medi-Cal through county websites and offices.¹²¹

3. Express Lane Eligibility: Uptake/Retention

In 2009, the Children's Health Insurance Program Reauthorization Act (CHIPRA) authorized Express Lane Eligibility (ELE), which uses a child's enrollment in a means-tested benefits program to verify their eligibility for Medicaid and the Children's Health Insurance Program (CHIP).¹²² In states with ELE, children in programs like the Special Supplemental Nutrition Program for Women, Infants and Children (WIC) can enroll in and renew Medicaid coverage automatically because eligibility requirements for most public benefits programs are more stringent than for Medicaid and CHIP.¹²³ Some states have also received waivers authorized by the Affordable Care Act (ACA) to enroll adults in Medicaid through means-tested benefits programs similar to ELE.¹²⁴ While California is not one of the 15 states/territories that currently offers ELE or an ELE-like program for adults, Assembly Bill (AB) 526 was introduced on February 13, 2019, by Assemblymember Petrie-Norris (D-Laguna Beach) to authorize WIC ELE.¹²⁵ Additionally, California previously offered an ELE-like program called *Express Lane En-*

114 Though it is possible that auto-renewing coverage may cause stress for families who are afraid of the public charge rule, we believe that the benefits of staying enrolled outweigh that risk.

115 It is plausible that passive disenrollment is the more common mechanism by which chilled people disenroll because active disenrollment requires first speaking with a benefits administrator who could educate and reassure beneficiaries. Also as previously noted, the passive option is often the most commonly "selected" choice, which in this case is both the choice to stay enrolled until coverage expires and the choice to allow coverage to lapse without submitting renewal paperwork. This view was supported by interview informant Steve Wallace. Steve Wallace (professor, UCLA), in discussion with an author, Los Angeles, CA, December, 20, 2018.

116 Wishner et al., "Medicaid Real-Time," V.

117 Wishner et al., "Medicaid Real-Time," 38.

118 This was developed in response to ACA requirements. Wishner et al., "Medicaid Real-Time," 36.

119 Ibid., 36, 38.

120 Ibid., 37.

121 Ibid., 36.

122 Sheila D. Hoag, "Spotlight on Express Lane Eligibility (ELE)," S28.

123 CHIPRA allows the following public agencies to support Express Lane Eligibility: SNAP, WIC, Temporary Assistance for Needy Families (TANF), National School Breakfast and Lunch Program, Housing Assistance, Homeless Assistance, Head Start, Child Support Enforcement, Native American Housing Assistance, and state Medicaid and CHIP programs. Kaiser Family Foundation, "Building an Express Lane Eligibility Initiative," 4.

124 Ibid.

125 "AB-526 Public Social Services: SSI/SSP," bill, California Legislative Information § (2019), https://leginfo.ca.gov/faces/billTextClient.xhtml?bill_id=201920200AB526.

rollment, which used data from CalFresh to target uninsured adults who had gained Medi-Cal eligibility through the optional adult ACA expansion.¹²⁶

With two-thirds of the chilled population consisting of children, ELE is a reasonable option for improving the Medi-Cal enrollment rates of chilled families.¹²⁷ We expect ELE to increase Medi-Cal uptake and retention for the same reasons as RTED—that simple, automatic systems improve participation.¹²⁸ As with RTED, ELE would help maintain coverage for individuals who would otherwise passively disenroll. Unlike RTED, ELE would not require marketing to increase new enrollment, as new Medi-Cal beneficiaries would be recruited automatically from the pool of uninsured individuals participating in other benefits programs.

For this policy option, we evaluate two versions of ELE that would facilitate automatic Medi-Cal enrollment and renewal: one based on WIC enrollment (i.e., AB 526) and the other using CalFresh.¹²⁹ While other means-tested benefits programs could be used for ELE, these programs either demonstrated low uptake for Medicaid enrollment in other states or an additional eligibility verification step would be required, making the process only semi-automatic.¹³⁰

126 We italicize *Express Lane Enrollment* and use ELE to refer to Express Lane Eligibility to help readers distinguish between the first program for adults and the second very similarly named program for children. CalFresh *Express Lane Enrollment* was phased out on June 30, 2017. Per Kristen Golden Testa of The Children's Partnership, there are no plans to restart this because CMS had additional requirements that DHCS did not want to pursue further.

Centers for Medicare & Medicaid Services, "Cost Sharing Out of Pocket Costs," Medicaid.gov, accessed February 12, 2019, <https://www.medicaid.gov/medicaid/cost-sharing/out-of-pocket-costs/index.html>.

Deborah Wong-Kochi, "Express Lane," HIPAA Title Information, August 18, 2017, <https://www.dhcs.ca.gov/services/medi-cal/eligibility/pages/expresslane.aspx>.

Kristin Golden Testa (Director of California Health Program, The Children's Partnership), email message to an author, February 13, 2019.

127 Ponce, Lucia, and Shimada, "Proposed Changes," Lecture, 31.

128 Sommers, "Loss of Health Insurance".

Kenney et al., "Children Eligible for Medicaid or CHIP."

Samuelson and Zeckhauser, "Status Quo Bias in Decision Making."

129 Sheila D. Hoag, "Spotlight on Express Lane Eligibility (ELE): A Tool to Improve Enrollment and Renewal," *Academic Pediatrics* 15, no. 3 (2015), accessed February 12, 2019, <https://doi.org/10.1016/j.acap.2015.02.010>

130 Sheila Hoag, Frederic Blavin, and Jennifer Edwards, "CHIPRA Mandated Evaluation of Express Lane Eligibility: Final Findings," CHIPRA Mandated Evaluation of Express Lane Eligibility: Final Findings, December 2013, <https://www.urban.org/sites/default/files/publication/60916/2000283-CHIPRA-Mandated-Evaluation-of-Express-Lane-Eligibility-Final-Findings.pdf>.

Adrin Nazarian, "Assembly Bill 422," Bill Text - AB 422: School Lunch Program Applications: Health Care Notice, 2013, Accessed February 12, 2019 http://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=201320140AB422.

CHAPTER 6

POLICY EVALUATION

We evaluate three policy alternatives that would reduce fear, increase Medi-Cal uptake, and/or increase Medi-Cal retention for the chilled population. Using evidence collected from the pertinent research literature, the semi-structured interviews and emails with informants, and the political feasibility survey, we calculate each option's efficacy, cost of implementation, cost-effectiveness ratio, and political feasibility. While we note when our calculations are likely to be underestimates or overestimates, the degree of imprecision in each case is small enough to leave our overall evaluation unchanged. Our evaluative comparison of the policy options based on these criteria follows.

1. Naturalization Campaign

Efficacy

In 2016, California was home to over 2,200,000 adults who were eligible to naturalize and become U.S. citizens (ETNs).¹³¹ USC's Center for the Study of Immigrant Integration (CSII) estimates the number of ETNs nationwide, and their probability of naturalizing over two years, based on various demographic dimensions (e.g., income, age, race/ethnicity, etc.).¹³² For example, those who have a low probability of naturalization (defined by CSII as a less than 9.7% chance of naturalization over two years) are generally older, have lower income, and have lower levels of formal education.¹³³ We rely on data from CSII and the Center for Health Policy Research (CHPR) as well as the New York City study on the impact of fee waiver eligibility notices to generate estimates of how many ETNs might naturalize due to our proposed campaign.¹³⁴ From this, we predict how many ETNs and their children would be diverted from disenrolling in Medi-Cal to arrive at our efficacy estimate.

Of the 740,000 ETNs in California who qualified for application fee waivers, 93.7% are likely already enrolled in Medi-Cal (further referred to as chilled ETNs).¹³⁵ Because CSII predicts that 37,000 to 114,000 fee waiver-eligible ETNs in California would normally naturalize over two years, we extrapolate that 35,000 to 106,000 chilled ETNs would do the same, assuming

131 USC, *Interactive Map*.

132 Ibid.

133 The mean probability of naturalization over two years nationwide is 15.7%. CSII defines low probability of naturalization as half a standard deviation or more lower than the mean probability of naturalization (i.e., 0-9.7%). Likewise, CSII defines high probability of naturalization as half a standard deviation or more above the mean probability of naturalization (i.e., 21.7% and up).
Thai V Le et al., *Paths to Citizenship: Using Data to Understand and Promote Naturalization*, rep. (USC Dornsife, January 2019), https://dornsife.usc.edu/assets/sites/731/docs/PathsToCitizenship_Full_Report_CSII.pdf, 3, 23.

134 USC, *Interactive Map*.

Ponce, Lucia, and Shimada, "Proposed Changes," Lecture.

Hotard et al., "Nudge Increases Citizenship Application Rates."

135 Because CHPR estimates the number of adults in the chilled population on federally funded Medi-Cal by excluding LPRs with less than five years of residency, all these adults would be eligible to naturalize as long as they were in good moral standing. CHPR estimates this number to be 693,000 chilled adults, which is 93.7% of 740,000. We also report population estimates rounded to the nearest thousand people. Because we performed calculations with non-rounded numbers, some calculations may appear slightly inaccurate.

Ponce, Lucia, and Shimada, "Proposed Changes," Lecture, 31.

USC, *Interactive Map*.

a 93.7% Medi-Cal participation rate by fee waiver-eligible ETNs.¹³⁶ Based on the New York City study's finding that notifying ETNs of their fee waiver eligibility could potentially increase naturalization rates by 35%, we assume that given a focused and deliberate program to identify and notify chilled Californians of their eligibility to naturalize with fee waivers, Californians would also naturalize at 135% of their usual rate.¹³⁷ This yields a total of 47,000 to 144,000 naturalizations over two years. To predict how many chilled people would be diverted from disenrolling in Medi-Cal, we assume that 15% of people who naturalized in response to fee waiver letters would have otherwise disenrolled (i.e., 2,000 to 6,000 ETNs).¹³⁸ With roughly two children per adult in the chilled population, we estimate that **5,000 to 17,000 chilled people** will stay enrolled as a result of this policy option (for methodological details, see Appendix J).¹³⁹

Cost

Our cost estimates are based on results from a New Americans Campaign (NAC) study, which analyzed programs offering naturalization services similar to those we proposed, like legal assistance and citizenship classes.¹⁴⁰ The NAC study calculated each program's costs including paid staff and resources, the number of in-person volunteer hours (from Board of Immigration Appeals-accredited representatives, lawyers, and others), and donations of in-kind resources like event space, media coverage, and food.¹⁴¹ It determined that the median combined costs of one naturalization application and one fee waiver application was \$328 if donations and contributions from volunteers were included, and \$490 if they were not.¹⁴² Given these per-person costs and our estimate of how many fee waiver-eligible ETNs would naturalize under our proposed program (47,000 to 144,000), this naturalization campaign would cost **\$15 million to \$47 million** on the low end, assuming contracted service providers relied on volunteers and donations.¹⁴³ If they relied entirely on state funding, this policy option would cost **\$23 million to \$70 million**.¹⁴⁴

In addition to the costs of naturalization support services, there would be additional costs to identifying the 740,000 fee waiver-eligible ETNs in state databases, mailing them notification letters, and coordinating efforts by direct service providers.¹⁴⁵ Because of insufficient data for factors like administrative costs, we are only able to predict that the cost of mailing letters would be around \$400,000, an amount small enough to not shift the cost estimates above.¹⁴⁶ Moreover, with such high predicted costs, these currently unquantifiable factors would probably not shift the overall price considerably but do make our predictions **underestimates**.¹⁴⁷

Cost-Effectiveness Ratio

To calculate the cost-effectiveness ratio, we divide the estimated costs (\$15 million to \$47 million with donations and \$23 million to \$70 million without) by the estimated efficacies

¹³⁶ Ibid.

¹³⁷ Hotard et al., "Nudge Increases Citizenship Application Rates."

¹³⁸ Ponce, Lucia, and Shimada, "Proposed Changes," Lecture, 16.

¹³⁹ Ponce, Lucia, and Shimada, "Proposed Changes," Lecture, 31.

¹⁴⁰ Ready California, "ONE California: Immigration Services Funding," Ready California, accessed February 13, 2019, <https://ready-california.org/resources/one-california-immigration-services-funding/>.
The Resource for Great Programs, Inc., *A Financial Analysis of Application Completion in the New Americans Campaign*, rep. (The New Americans Campaign, July 25, 2014), <https://newamericascampaign.org/wp-content/uploads/2017/04/Financial-Analysis-Full-Report.pdf>.

¹⁴¹ Local partners would be responsible for leveraging volunteers and in-kind donations.
The Resource, *New Americans Campaign*, 3-4 - 5-7.

¹⁴² Targeting rural locations or areas lacking public transportation would increase the average application cost.
Ibid., ii-iii; 4-3 - 4-6.

¹⁴³ Ibid., ii; 4-3 - 4-6.

U.S. Bureau of Labor Statistics, "CPI Inflation Calculator," U.S. Bureau of Labor Statistics (U.S. Bureau of Labor Statistics), accessed February 8, 2019, <https://data.bls.gov/cgi-bin/cpicalc.pl>. Adjusted for inflation using January 2019, USD.

¹⁴⁴ U.S. BLS, "CPI Inflation Calculator." Adjusted for inflation using January 2019, USD.

¹⁴⁵ Costs of direct mail marketing are minor, relative to the overall projected costs of the policy option. Jenna Bruce, "How Much Does Direct Mail Marketing Cost?," Mediaspace Solutions, July 31, 2017, <http://www.mediaspacesolutions.com/blog/how-much-does-direct-mail-marketing-cost>.

¹⁴⁶ This is the cost of 740,000 letters sent at the current first-class mail rate of \$0.55.

¹⁴⁷ Bruce, "Mail Marketing."

(5,000 to 17,000 chilled people). We predict that this naturalization program would have a cost-effectiveness ratio of **\$1,458 per person** (assuming the *highest* predicted number of naturalizations with costs offset by volunteers and donations) to **\$2,178 per person** (assuming the *lowest* predicted number of naturalizations with full funding from the state).¹⁴⁸

Political Feasibility

Results from the political feasibility survey indicate that the naturalization program we propose has **high political feasibility** and could likely be enacted by the California Legislature and signed by the governor with minimal resistance. Nearly three-quarters of informants believed a naturalization campaign to be politically viable, with most believing it to be highly viable. However, the minority who did not rate this option as highly feasible believed it to be highly infeasible, indicating high polarization among informants. Because we did not ask respondents to explain their answer choices, we can only speculate that those who felt it infeasible may have found the assumed cost of \$20 million to be prohibitive, or that policies with benefits so focused on immigrants were generally infeasible.

These survey results are consistent with the current political climate in California, which is generally pro-immigrant amongst policymakers and the general public. In 2018, California formalized its status as a leader in protecting immigrants by enacting the California Values Act, thus becoming a “sanctuary state” for undocumented immigrants.¹⁴⁹ This law limits the ways in which local law enforcement agencies are permitted to cooperate with the federal government on immigration laws, codifying California’s resistance to the federal government’s draconian approach to immigrants.¹⁵⁰ Newly-elected Democratic Governor Gavin Newsom re-emphasized the need to provide sanctuary to undocumented immigrants in his 2019 inaugural speech in direct opposition to President Trump’s actions.¹⁵¹ Furthermore, Democrats now hold supermajorities in both houses of the California Legislature, making it harder for Republican opponents to block immigrant-friendly legislation.¹⁵²

Despite the divisive politics surrounding immigration, naturalization is an approach that enjoys the support of a majority of Republicans, increasing the political feasibility of our proposed policy option.¹⁵³ Fiscally conservative lawmakers often extol the economic mobility and subsequent decrease in reliance on public benefits that come with naturalization.¹⁵⁴ Moreover, those who are wary of expanding government supported services may find this naturalization program acceptable considering it would only require a relatively small expansion of the existing One California program.¹⁵⁵ Because One California is already slated to receive \$65 million in FY 2019-2020, the naturalization program’s projected costs of up to \$104 million over two years may be

148 Calculations were made with non-rounded efficacy and cost estimates.

149 Taryn Luna, “California Voters like ‘Sanctuary State’ Immigration Law – but Not Everyone Is on Board,” *The Sacramento Bee* (The Sacramento Bee, April 27, 2018), <https://www.sacbee.com/news/politics-government/capitol-alert/article209906949.html>.
Samantha Raphelson, Jeremy Hobson, and Chris Bentley, “California Sanctuary Law Divides State In Fierce Immigration Debate,” NPR (NPR, October 17, 2018), <https://www.npr.org/2018/10/17/657951176/california-sanctuary-law-divides-state-in-fierce-immigration-debate>.

150 Raphelson, Hobson and Bentley, “California Sanctuary Law.”

151 CBS Los Angeles, “California Governor Newsom Vows ‘Sanctuary To All Who Seek It’ In Inauguration Speech,” CBS Los Angeles (CBS Los Angeles, January 7, 2019), <https://losangeles.cbslocal.com/2019/01/07/gavin-newsom-california-governor-2/>. Reprinted via AP.

152 Don Thompson, “Democrats Gain Veto-Proof Majority in California Legislature,” U.S. News & World Report (U.S. News & World Report, November 12, 2018), <https://www.usnews.com/news/best-states/california/articles/2018-11-12/democrats-gain-veto-proof-majority-in-california-legislature>.
State of California, “Senators,” California State Senate, accessed February 9, 2019, <https://www.senate.ca.gov/senators>.
State of California, “Members,” California State Assembly, accessed February 9, 2019, <https://www.assembly.ca.gov/assemblymembers>.

153 Rafael Bernal, “Poll: Majority of Republicans Support Path to Citizenship,” (The Hill, March 29, 2016), <https://thehill.com/home-news/news/274575-poll-majority-of-republicans-support-path-to-citizenship>.
Polling in the article was done at the national level.

154 Madeleine Sumption and Sarah Flamm, *The Economic Value of Citizenship for Immigrants in the United States*, rep., September 2012, <https://www.migrationpolicy.org/sites/default/files/publications/citizenship-premium.pdf>.

155 Governor’s Office, “2019-20 Governor’s Budget.”
Jazmine Ulloa, “Nearly \$50 Million in the California State Budget Will Go to Expanded Legal Services for Immigrants,” *Los Angeles Times*, June 15, 2017, <https://www.latimes.com/politics/essential/la-pol-ca-essential-politics-updates-nearly-50-million-in-the-california-1497576640.htmlstory.html>.
CDSS, “Immigration Fact Sheet.”
California Immigrant Policy Center, “Immigrant Services Funding.”

covered by existing funding (if it can be spent flexibly) or may require only minimal increases in funding.¹⁵⁶ This approach may appeal particularly to conservative lawmakers, as it could appear as more of a best practices approach to an existing program than a new cost.

Because One California provides naturalization services, a policy window opened for these services when it was created.¹⁵⁷ Additionally, because One California provides the bureaucratic infrastructure to develop expanded naturalization services, a policy window remains open for this option.¹⁵⁸ However, it is important to note that despite Governor Newsom's expected hands-on style of executive-led policymaking, research shows that executive style in promoting legislative objectives, controlling for other factors, has minimal impact on the success or failure of public policy.¹⁵⁹ Overall, given the results of the political feasibility survey, public polling on naturalization, and the existing policy window given the current programmatic infrastructure to take this on, we predict the naturalization policy option to be highly viable.¹⁶⁰

2. Real-Time Eligibility Determination (RTED)

Efficacy

To predict efficacy, we estimate the number of chilled people currently on Medi-Cal who could automatically be renewed as a result of gaining real-time eligibility determination (RTED), thus being diverted from passively disenrolling. In California, 40-60% of renewals are already automated through systems with limited RTED capabilities.¹⁶¹ A case study from the Urban Institute that compares California's systems to Washington's RTED-based enrollment and renewal system noted that Washington could automatically renew coverage for 73% of beneficiaries.¹⁶² If California's systems could be improved to match the renewal rates in Washington, then automatic renewals could increase by 13 to 33 percentage points.

To simplify calculations, we assume that all chilled people who disenroll will do so passively by letting their coverage lapse at renewal periods rather than actively calling benefits offices.¹⁶³ Thus, an additional 13-33% of the 317,000 predicted disenrollees, or **41,000 to 105,000 chilled people**, could be diverted from disenrolling through automatic renewals.¹⁶⁴ Because it is unknown how chilled people may differ from other Medi-Cal beneficiaries in their propensity to desire coverage or their likelihood of enrolling in multiple programs, we assume that they will behave similarly to average Medi-Cal beneficiaries.

In addition to the impacts on retention, RTED streamlines enrollment through eliminating in-

156 California Department of Social Services, "Immigration Services Funding Fact Sheet."

157 Kingdon, "The Policy Window," 168-69, 173-75.

158 Ibid.

159 While both Peterson's and Beckman's books study presidential policies, we extrapolate its findings to understand executive action at the state level.

Ben Adler, "In Style And Substance, Gavin Newsom Goes His Own Way," KPBS Public Media (KPBS, February 8, 2019), <https://www.kpbs.org/news/2019/feb/08/style-and-substance-gavin-newsom-goes-his-own-way/>.

Scott Shafer, "High Expectations on the Left for Governor-Elect Gavin Newsom," KQED, November 7, 2018, <https://www.kqed.org/news/11703925/high-expectations-on-the-left-for-governor-elect-gavin-newsom>.

Jeremy B White, "What to Expect from Gavin Newsom: A POLITICO California Pro Policy Primer," POLITICO (POLITICO, November 7, 2018), <https://www.politico.com/states/california/story/2018/11/05/what-will-newsom-do-as-governor-heres-a-policy-primer-684200>.

Mark A. Peterson, "Table 7.3," table, in *Legislating Together: the White House and Capitol Hill from Eisenhower to Reagan* (Cambridge, MA: Harvard University Press, 1990).

Matthew Beckmann, based on Figure 5.6, in *Pushing the Agenda: Presidential Leadership in U.S. Lawmaking, 2003-2004* (Cambridge, MA: Cambridge University Press, 2010), p. 146.

160 Kingdon, "The Policy Window," 168-69, 173-75.

161 Wishner et al., "Medicaid Real-Time," 37.

162 The remaining 27% undergo manual renewals. Wishner et al., "Medicaid Real-Time," 24.

163 This is not an unreasonable approximation because we guess that most disenroll passively. Those who try to actively disenroll would have to speak with a benefits administrator first who could reassure and encourage the chilled person to stay enrolled, which requires greater effort than passive disenrollment. This view was supported by immigrant health expert Steve Wallace in an interview on December 20, 2018.

Steve Wallace (professor, UCLA), in discussion with an author, Los Angeles, CA, December, 20, 2018.

164 $2,116,000$ in the chilled population \times .15 disenrollment rate = $317,400$ \times .13 = $41,262$; $317,400$ \times .33 = $104,742$. We round to the thousands.

Ponce, Lucia, and Shimada, "Proposed Changes: Data Tables," 2.

come-verification paperwork and approving applications almost instantaneously by verifying data using the Federal Hub.¹⁶⁵ Washington's RTED-based system can do this for at least 75% of applicants, compared to just 25-50% in California, demonstrating significant room for growth.¹⁶⁶ Even though there are an estimated 123,000 noncitizens who are uninsured but Medi-Cal eligible, we are unable to predict how many of these individuals would enroll after expanding RTED.¹⁶⁷ There have been no advertising efforts to publicize CalHEERS for Medi-Cal enrollment.¹⁶⁸ Therefore, we assume that without heavy advertising, people would be unaware of a simpler enrollment system they feel capable of using to sign up for Medi-Cal.¹⁶⁹ Thus, we do not count potential new enrollees in our efficacy estimate and instead note that it is an **underestimate**. Additionally, we assume that expanding RTED would have virtually identical impacts regardless of the mechanism used because both mechanisms rely on the same process to automate renewals. Therefore, we estimate the potential efficacy to be the same across both mechanisms.

Cost

Each RTED expansion mechanism has different implementation costs based on varying levels of required technical upgrades, staff training, and administrative overhead. We do not include the cost for renewing beneficiaries because government analyses of healthcare reform bills do not generally include this figure.¹⁷⁰ Although the cost of insuring new enrollees is typically included in government analyses, we assume uptake will increase only marginally, meaning that the cost of new enrollees would be negligible.¹⁷¹ Therefore, we only consider technical upgrades, staff training, and administrative overhead costs in these estimates, and do not include costs of new enrollees or renewed beneficiaries. Details of the methodology used to calculate cost for the various mechanisms of expanding RTED follow below.

A) Increase reliance on California Healthcare Eligibility, Enrollment and Retention System (CalHEERS): Because CalHEERS is already capable of performing RTED, no technical upgrades are required, and cost depends only on administrative overhead and training.¹⁷² However, CalHEERS can only manage Medi-Cal enrollment and renewals, so administrators would need to enter data into two systems (CalHEERS and the Statewide Automated Welfare System, or SAWS) if beneficiaries wanted to also enroll in benefits programs other than Medi-Cal.¹⁷³ This would increase the time required to process applications for multiple benefits programs, presumably creating costly inefficiencies.¹⁷⁴ Still, the Centers for Medicare and Medicaid Services predicts large financial gains from this policy option.¹⁷⁵ This policy option requires that only CalHEERS be used to process Medi-Cal

¹⁶⁵ Ibid., 36.

¹⁶⁶ Tricia Brooks et al., *Medicaid and CHIP Eligibility, January 2017 Enrollment, Renewal, and Cost Sharing Policies as of January 2017: Findings from a 50-State Survey*, rep., (The Henry J. Kaiser Family Foundation, January 2017), <http://files.kff.org/attachment/Report-Medicaid-and-CHIP-Eligibility-as-of-Jan-2017>, 33.

Wishner et al., "Medicaid Real-Time," 6.

¹⁶⁷ We are unable to generate population estimates for Medi-Cal eligible citizen children of noncitizen parents. Thus, this number is an underestimate of the maximum number of people in our population of focus that can be captured by improved enrollment methods. UCLA Center for Health Policy Research, AskCHIS 2015-16 pooled data, Eligibility of Uninsured under 65 for Medi-Cal (MAGI guidelines) by Citizenship and Immigration Status, http://ask.chis.ucla.edu/AskCHIS/tools/_layouts/AskChisTool/home.aspx#/results, accessed February 10, 2019.

¹⁶⁸ Covered California has marketed CalHEERS, but the Urban Institute expects this marketing only attracts people using CalHEERS to apply for insurance on the ACA health exchanges. There has been no marketing done by Medi-Cal. Wishner et al., "Medicaid Real-Time," 38.

¹⁶⁹ Ibid.

¹⁷⁰ Samantha Liu, "Assembly Bill 257." Bill Analysis - AB-2579 Medi-Cal: Special Supplemental Nutrition Program for Women, Infant, and Children, 2018." https://leginfo.ca.gov/faces/billAnalysisClient.xhtml?bill_id=201720180AB2579 California Health and Human Services Agency California Department of Health Care Services. "Medi-Cal Eligibility Data System Modernization Multi-Departmental Planning Team," January 10, 2017. http://web1a.esd.dof.ca.gov/Documents/bcp/1718/FY1718_ORG0530_BCP1135.pdf, 1-2, 8, 9.

¹⁷¹ Samantha Liu, "Assembly Bill 2579." California Health and Human Services Agency. "Medi-Cal Eligibility Data System," 1, 8, 9.

¹⁷² The short-term costs of systems upgrades are already in the state budget. "Fiscal Year 2018-2019 Budget," Covered California, June 15, 2018. https://hbex.coveredca.com/financial-reports/PDFs/Covered-CA_2018-19_Budget-6-15-18.pdf, 64-5.

¹⁷³ Wishner et al., "Medicaid Real-Time," 36.

¹⁷⁴ Ibid.

¹⁷⁵ Centers for Medicare and Medicaid Services, "Medicaid Program."

enrollments and renewals, instead of the status quo where both CalHEERS and SAWS are used. The Centers for Medicare and Medicaid Services estimates that eliminating the use of older Medi-Cal enrollment and eligibility systems (SAWS) and only using one system (CalHEERS) would result in cost savings by 2025, offsetting the previous inefficiency of this mechanism.¹⁷⁶ Additionally, county officials have already been trained on CalHEERS, although some may need a refresher if they have not been using the system.¹⁷⁷ We expect these trainings to cost up to \$363,000 based on similar trainings that were listed in the FY 2018-2019 Covered California budget.¹⁷⁸ Hence, we predict this mechanism's cost of implementation to be **less than \$363,000**.

B) Upgrade SAWS: SAWS already connects to CalHEERS to access data from the Federal Hub, but this connection is not used regularly or effectively to provide RTED.¹⁷⁹ Because of the existing connection, we expect that minimal technical upgrades would be required in order for SAWS to better utilize the Federal Hub to improve rates of RTED. One way to achieve this goal may be to connect SAWS directly to the Federal Hub. We presume this process will be no more complex and costly than connecting the Special Supplemental Program for Women, Infants, and Children (WIC) system to CalHEERS and SAWS based on information provided by our programmer informant.¹⁸⁰ The WIC-CalHEERS-SAWS data transfer system upgrade and associated training were estimated to cost the state \$100,000 (the low cost is due to a 90% federal match).¹⁸¹ Because we are unsure if the upgrade to SAWS would receive a similar federal match, we project the cost assuming it receives no federal funding. Therefore, we expect that upgrading SAWS to connect to the Federal Hub for RTED would cost **\$1 million**.¹⁸²

Cost-Effectiveness Ratio

To calculate cost-effectiveness ratios for each mechanism, we divide the estimated costs (\$363,000 and \$1 million, respectively) by the estimated efficacy (41,000 to 105,000 chilled people) and obtain the following values, rounded to the nearest dollar:

A) Increase reliance on CalHEERS: \$3 to \$9 per person

B) Upgrade SAWS: \$10 to \$24 per person

Political Feasibility

Our political feasibility survey asked general questions about RTED without distinguishing between the two mechanisms. Like naturalization, nearly three-quarters of respondents felt that RTED was politically feasible. However, few felt that it was strongly feasible or infeasible, unlike naturalization. These survey results differ from data provided by our informant interviews and the Urban Institute's case study on implementing RTED in California, all of which found RTED to likely face political challenges.¹⁸³ These differences in assessments of political feasibility may have been due to informants having varying understandings of California's county benefits department culture.

We anticipate that there will be significant push back from county administrators and staff against both mechanisms because each requires changes to existing county processes. Informants noted that this resistance would be due to a strong county preference for the status

¹⁷⁶ Ibid.

¹⁷⁷ Wishner et al., "Medicaid Real-Time," 36.

¹⁷⁸ We round to the thousands. Because it cost \$363,000 to train staff on two new systems, we predict that providing a refresher training on one system will be simpler.
"Fiscal Year 2018-2019 Budget," Covered California, 85.

¹⁷⁹ Wishner et al., "Medicaid Real-Time," 36-7.

¹⁸⁰ Mitchell Jacobs (QA Engineer, MFour Mobile Research), in discussion with an author, Los Angeles, CA, February 7, 2019.

¹⁸¹ Kristen Golden Testa (Director of California Health Program, The Children's Partnership), email message to the authors, February 7, 2019.

¹⁸² Ibid.

Of course, if a federal match can be obtained, then the cost would be substantially less (i.e., \$100,000 total).

¹⁸³ Wishner et al., "Medicaid Real-Time," 33.

quo, which in this case is to rely solely on SAWS without making upgrades to the system.¹⁸⁴ Legislators may then be reluctant to advocate for RTED expansion, as county welfare directors have a strong lobbying presence through the County Welfare Directors Association of California.¹⁸⁵ Even if an RTED expansion bill were to pass, county officials could still delay policy implementation in order to avoid change. The Urban Institute finds that, “The disruption for county workers in particular can be challenging,” and quotes a Medi-Cal official in its report, stating, “Ultimately, the technology isn’t the barrier. The barrier is the culture change.”¹⁸⁶ Thus, county culture represents the most significant challenge to the political feasibility of RTED. Additionally, no policy window exists for this option as there is currently no proposed state-level legislation to promote RTED expansion and no identifiable shift in county sentiment on RTED.¹⁸⁷

If county offices became more amenable to increasing the usage of RTED and an RTED expansion bill was introduced, there could be potential for state-level support. Governor Newsom has expressed a commitment to increasing access to health care and investing in Medi-Cal to improve quality of care.¹⁸⁸ These proposed financial commitments suggest that the governor could support this policy option if it were to pass through the legislature. Representatives who supported the unsuccessful Assembly Bill (AB) 2965, which aimed to expand Medi-Cal coverage to undocumented immigrants, could be sought out as advocates for this policy given their track record of supporting health care expansion.¹⁸⁹ Regardless of potential future state-level support for RTED expansion, the current lack of a policy window and anticipated resistance from county staff means that RTED has **low political feasibility** at this time. A more nuanced discussion for each mechanism follows below:

A) Increase reliance on CalHEERS: CalHEERS only processes applications for Medi-Cal, meaning those who want to enroll in other programs must submit separate applications through the county SAWS system.¹⁹⁰ Therefore, a greater reliance on CalHEERS would burden individuals wanting to apply to two or more programs, potentially reducing their enrollment rates in public benefits programs overall.¹⁹¹ This tradeoff may discourage legislators or service organizations from supporting this approach, further lowering its political feasibility.

184 Steve Wallace (professor, UCLA), in discussion with an author, Los Angeles, CA, December, 20, 2018.
Almas Sayeed (Deputy Director of Programs, California Immigrant Policy Center), in discussion with an author, Los Angeles, CA, January 10, 2019.
Adam Barsch (Program Specialist, Arapahoe County Human Services), email message to an author, February 23, 2019.

185 The County Welfare Directors Association of California has helped pass policies relating to welfare reform, the creation of CalWORKS, and co-sponsored legislation to expand foster care services.
“About CWDA,” County Welfare Directors Association of California, accessed March 1, 2019, <https://www.cwda.org/about-cwda>.
“History,” County Welfare Directors Association of California, accessed April 22, 2019, <https://www.cwda.org/history>.
Steve Wallace (professor, UCLA), email message to author, February 7, 2019.

186 Wishner et al., “Medicaid Real-Time,” 33

187 The last major policy changes to the Medi-Cal enrollment system were 1) a 2011 policy to migrate one of the SAWS into the other and 2) a 2014 policy to designate roles between the systems (e.g., deciding which system would send an eligibility notice to an enrollee or what information should be stored in which system).
Kingdon, “The Policy Window,” 168-69, 173-75.
ABX1 16, bill, California Legislative Information § (2011), http://www.leginfo.ca.gov/pub/11-12/bill/asm/ab_0001-0050/abx1_16_bill_20110908_enrolled.html.
SB-1341, bill, California Legislative Information § (2014), http://leginfo.legislature.ca.gov/faces/billTextClient.xhtml?bill_id=201320140SB1341.

188 “Governor Newsom’s Budget Makes Important Investments in Health Equity and Prevention,” cpehn.org (California Pan-Ethnic Health Network, January 11, 2019), <https://cpehn.org/policy-center/state-budget>.

189 These representatives include Assemblymember Joaquin Arambula (D-Fresno), Assemblymember David Chiu (D-San Francisco), and Assemblymember Phil Ting (D-San Francisco).
Angela Hart, “More Undocumented Immigrants Would Qualify for Health Care in \$250 Million California Plan,” *sacbee.com* (The Sacramento Bee, May 8, 2018), <https://www.sacbee.com/news/politics-government/capitol-alert/article210645664.html>.

190 Wishner et al., “Medicaid Real-Time,” 39.

191 Ibid., 36.

B) Upgrade SAWS: Most Medi-Cal applications are completed through the county-based welfare systems.¹⁹² This suggests that upgrading SAWS to have RTED would be more politically feasible than the other mechanism because it allows for continued reliance on existing county-based processes and requires less significant workflow changes for county administrators. However, due to administrative resistance to *any* changes at the county-level and the lobbying capacity of county directors, this mechanism has limited political feasibility.¹⁹³

3. 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 noncitizen immigrants 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**.¹⁹⁴

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.¹⁹⁵ Currently, 40% to 60% of all Medi-Cal beneficiaries must go through manual renewal processes.¹⁹⁶ 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**. Details of the methodology used for WIC ELE and CalFresh ELE follow below.

A) WIC: According to the California Health Interview Survey (CHIS), there were 4,000 uninsured noncitizen mothers enrolled in WIC who were Medi-Cal eligible in 2017, representing the pool of immigrant mothers who could benefit from WIC ELE.¹⁹⁷ Based on estimates provided by the California Senate Health Committee, we approximate that there are roughly 3.9 children per mother in the uninsured WIC population.¹⁹⁸ Using this approximated ratio, we estimate that there are a total of 20,000 **mothers, infants, and children in immigrant families** who could gain Medi-Cal by enrolling through WIC ELE (i.e., efficacy of *uptake*). To calculate the efficacy of *retention*, we consider that there

192 Wishner et al., "Medicaid Real-Time," 36-7.

193 "About CWDA," County Welfare Directors Association of California. Steve Wallace (professor, UCLA), email message to author, February 7, 2019.

194 Presumably, those who are enrolled in WIC or CalFresh, but not 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, as previously discussed in Chapter 5.

195 As previously described in the RTED efficacy evaluation section (footnote #165), it is a reasonable assumption that most will disenroll passively and is a view supported by at least one of our expert informants, Steve Wallace. Steve Wallace (professor, UCLA), in discussion with an author, Los Angeles, CA, December, 20, 2018.

196 Wishner et al., "Medicaid Real-Time," 37.

197 UCLA Center for Health Policy Research, AskCHIS 2017, Adults in households that received WIC benefits in the past year, Citizenship and immigration status, Eligibility of Uninsured under 65 for Medi-Cal (MAGI guidelines), Family type, http://ask.chis.ucla.edu/AskCHIS/tools/_layouts/AskChisTool/home.aspx#/results, accessed February 10, 2019.

198 Samantha Liu, "Assembly Bill 2579."

The California Senate Health Committee analysis for AB 2579, the failed WIC-ELE bill, estimated that there were 90,000 children and 23,000 pregnant women of all immigration statuses were uninsured but Medi-cal eligible. This is a ratio of 3.9 uninsured children per uninsured woman within WIC. As previously mentioned, we assume that family size characteristics will be similar for the chilled population due to a lack of data about sub-group behavior.

are roughly 242,000 noncitizen mothers who are enrolled in both WIC and Medi-Cal.¹⁹⁹ Additionally, there are approximately 2.7 children per mother in the dually enrolled WIC and Medi-Cal population, meaning that roughly 654,000 chilled children are also dually enrolled.²⁰⁰ Adding these two values, we estimate that there are 896,000 chilled mothers and children enrolled in both WIC and Medi-Cal. We predict that 15% of these chilled people (**134,000 chilled people**) would have disenrolled in Medi-Cal without intervention, thus representing the pool of those who could be diverted toward staying enrolled through WIC ELE.²⁰¹ Combining uptake and retention estimates, 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.²⁰²

B) CalFresh: There are approximately 860,000 CalFresh enrollees who live in immigrant families.²⁰³ Because Medi-Cal already covers 98% of CalFresh enrollees, we conclude that 843,000 chilled CalFresh enrollees have Medi-Cal.²⁰⁴ This means that approximately 17,000 noncitizen immigrants and their dependents are uninsured but enrolled in CalFresh.²⁰⁵ Therefore, we estimate that 17,000 people in immigrant families could gain Medi-Cal coverage through CalFresh ELE (i.e., efficacy of *uptake*).²⁰⁶ To estimate the efficacy of *retention*, we once again assume that all chilled people would passively rather than actively disenroll. Thus, CalFresh ELE could divert 15% of the 843,000 dually enrolled chilled people (**126,000 chilled people**) away from disenrolling (i.e., efficacy of *retention*).²⁰⁷ Combining uptake and retention estimates, up to **143,000 CalFresh enrollees in immigrant families** could benefit from CalFresh ELE.²⁰⁸ As with WIC ELE, this is an **overestimate** for reasons previously stated.

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. As with RTED, we include the cost of newly enrolled beneficiaries, but not those who would stay enrolled, due to gaining auto-renewal as all analyses we relied on for our estimates did not consider the cost of increased renewal rates.

A) WIC: 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.²⁰⁹ 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

199 Center for Health Policy Research, AskCHIS 2015-2016 pooled data, Adults in households that received WIC benefits in the past year, Gender, Citizenship and Immigration Status, Family Type, Type of current health insurance coverage.

200 Of the 1.1 million WIC participants in 2018, 27% were mothers, and the remaining 73% were infants and children, giving a ratio of 2.7 dependents per mother. Estimate is rounded to nearest thousand.

Center for Health Policy Research, AskCHIS 2015-2016 pooled data, Adults in households that received WIC benefits in the past year, Gender, Citizenship and Immigration Status, Family Type, Type of current health insurance coverage. California WIC, "How WIC Helps the Golden State," March 2018, <https://s3.amazonaws.com/aws.upl/nwica.org/2018-ca-wic-fact-sheet.pdf>.

201 Estimate rounded to nearest thousand.

202 Estimate rounded to the nearest thousand.

203 Ponce, Lucia, and Shimanda, "Proposed Changes," Lecture, 24.

204 "Medi-Cal and CalFresh Enrollment," CHHS Open Data, California Health and Human Services Agency, <https://data.chhs.ca.gov/dataset/medi-cal-and-calfresh-enrollment>, accessed March 1, 2019.

205 "Medi-Cal and CalFresh Enrollment," CHHS Open Data.

206 We are unable to determine how the uninsurance rates of noncitizen CalFresh beneficiaries compares to that of citizen CalFresh beneficiaries. Therefore, we assume that noncitizen CalFresh enrollees have similar uninsurance rates to the general pool of CalFresh enrollees. Estimate is rounded to nearest thousand.

Ponce, Lucia, and Shimada, "Proposed Changes," Lecture, 24.

207 Estimate is rounded to nearest thousand.

208 Estimate rounded to the nearest thousand.

UCLA Center for Health Policy Research, AskCHIS 2015-16 pooled data, Age group (4 categorical levels), Type of current health insurance (all ages), Currently receiving food stamps. http://ask.chis.ucla.edu/AskCHIS/tools/_layouts/AskChisTool/home.aspx#/results. Accessed March 6, 2019.

209 Samantha Liu, "Assembly Bill 2579."

required to absorb the cost of new enrollees.²¹⁰ 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.²¹¹ We favor this estimate rather than the Senate's, as it uses an average per-person cost similar to that found in other literature.²¹² Additionally, this program cost of \$104 million is relatively high but accounts for increased enrollment from all Californians, not just chilled people.

B) CalFresh: In 2014, California obtained a federal waiver to implement *Express Lane Enrollment*, an optional Affordable Care Act (ACA) expansion similar to ELE, which targeted low-income and uninsured adults enrolled in CalFresh.²¹³ In FY 2014-2015, California appropriated \$22.7 million toward necessary upgrades to both CalHEERS and SAWS interfaces to launch *Express Lane Enrollment*.²¹⁴ Therefore, we expect that minimal funding is required for technical upgrades to implement CalFresh ELE. Instead, implementation costs would primarily be due to the 85,000 people who could potentially enroll in Medi-Cal through CalFresh ELE.²¹⁵ At an average monthly cost of \$220 per new Medi-Cal enrollee, total program costs would be **\$224 million**.²¹⁶ This is an **overestimate** because those who became eligible for Medi-Cal through the optional ACA expansion (mostly low-income, childless adults) received 94% federal matching funds instead of only 50% like most other enrollees.²¹⁷

Cost-Effectiveness Ratio

Based on our efficacy and inflation-adjusted cost estimates, we calculate the following cost-effectiveness ratios for the two ELE mechanisms:

A) WIC: 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**.

B) CalFresh: With an extra 143,000 chilled people receiving Medi-Cal coverage at a cost of \$224 million, CalFresh ELE has a cost-effectiveness ratio of **\$1,560 per person**.

Political Feasibility

Similar to RTED, our political feasibility survey asked respondents for their opinions about ELE without distinguishing between WIC and CalFresh enrollment mechanisms. Survey respondents were split about its political feasibility. Those who felt it was viable generally agreed that ELE would face significant challenges to pass, perhaps because respondents were

210 Our estimates indicate costs to the State General Fund and exclude additional federal matching funds for upgrades and full-scope Medi-Cal beneficiaries.
Ibid.

211 Neither the California Senate Appropriations Committee nor The Children's Partnership considers costs associated with improved renewal rates made possible by auto-renewals with WIC ELE.
Kristen Golden Testa (Director of California Health Program, The Children's Partnership), email message to an author, February 7, 2019.

212 The Children's Partnership assumes a monthly cost of \$233 per enrollee given a 50/50 federal match versus the UCLA Center for Health Policy Research's assumption of \$220 per person per month.
Kristin Golden Testa (Director of California Health Program, The Children's Partnership), email message to an author, January 24, 2019.
Ponce, Lucia, and Shimada, "Proposed Changes," 3.

213 Sheila D. Hoag, "Spotlight on Express Lane Eligibility (ELE)," S31.

214 The total cost was significantly higher, but California received a high rate of federal matching funds.
Mac Taylor, "Integrating Health and Human Services Eligibility and Enrollment Processes," *Improving In-Prison Rehabilitation Programs*, October 30, 2014, accessed February 12, 2019, <https://lao.ca.gov/reports/2014/hhs/integrating-hhs-eligibility/integrating-hhs-eligibility-103014.aspx>.

215 This is the number of people who are currently receiving food stamps but are uninsured and Medi-Cal eligible.
UCLA Center for Health Policy Research, AskCHIS 2015-16 pooled data, Currently receiving Food Stamps, Eligibility of Uninsured under 65 for Medi-Cal (MAGI guidelines), http://ask.chis.ucla.edu/AskCHIS/tools/_layouts/AskChisTool/home.aspx#/results, accessed March 1, 2019.

216 Ponce, Lucia, and Shimada, "Proposed Changes," 3.

217 Ibid.

Mac Taylor, "The 2014-15 Budget: Analysis of the Health Budget," rep., *The 2014-15 Budget: Analysis of the Health Budget* (Legislative Analyst's Office, February 20, 2014), <https://lao.ca.gov/reports/2014/budget/health/health-022014.pdf>, 8.

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 and diffused costs to those who are Medi-Cal-eligible, providing the basis for political mobilization by health and immigrant rights advocates.²¹⁸ The political viability of WIC- and CalFresh-specific ELE are discussed below.

A) WIC: 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.²¹⁹ Reportedly, a lack of support from then-Governor Brown eventually led AB 2579 to stall in the Senate Appropriations Committee.²²⁰ 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.²²¹ An anonymous expert familiar with this legislation further substantiated this claim stating that the election of Governor Newsom has built momentum and created a policy window for WIC ELE via AB 526.²²² 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 526.²²³ However, despite Governor Newsom’s support, this policy would still likely require stakeholders to advocate directly the Assembly and Senate Budget Committees ahead of its passage.²²⁴ Thus, we predict that WIC ELE, as it would be established through AB 526, will have **medium political feasibility**.

B) CalFresh: Since CalFresh *Express Lane Enrollment* was discontinued on July 1, 2017, no proposals have been introduced in the California Legislature for a restart of the program.²²⁵ Moreover, *Express Lane Enrollment* had originally been approved through a temporary federal flexibility option that no longer exists.²²⁶ In order for the state of California to restart CalFresh *Express Lane Enrollment*, it would need to request a formal waiver (much like for ELE) or get household information from tax filings to process Medi-Cal renewals.²²⁷ Because restarting CalFresh *Express Lane Enrollment* would be quite cumbersome and unlikely to pass with its current lack of stakeholder support, we expect CalFresh ELE would have **low political feasibility**.

218 Stone, “Equity,” 221-2.

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

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

221 “Governor Newsom’s Budget,” cpehn.org.

Mike Odeh (Director, Health Policy, Children Now), email message to the authors, February 22, 2019.

222 Anonymous source, phone call with an author, March 14, 2019.

223 Anonymous source, phone call with an author, March 14, 2019.

224 Mike Odeh (Director, Health Policy, Children Now), email message to the authors, February 22, 2019.

225 Wong-Kochi, “Express Lane.”

226 Tricia Brooks, “States Could Lose Cost-Effective Express Lane Eligibility If Congress Fails to Extend CHIP Promptly,” Center For Children and Families, Last Accessed: February 12, 2019, <https://ccf.georgetown.edu/2017/09/13/states-could-lose-cost-effective-express-lane-eligibility-without-chip-renewa>.

227 Kristin Testa (Director of California Health Program, The Children’s Partnership), email message to an author, February 13, 2019.

CHAPTER 7

POLICY RECOMMENDATION – WIC ELE

In order to best mitigate disenrollment from Medi-Cal by the chilled population, we recommend that the California Immigrant Policy Center (CIPC) support the authorization and implementation of Express Lane Eligibility (ELE) as it offers the highest efficacy (see Table 3 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), rather than introducing a competing CalFresh ELE legislative proposal.²²⁸ Although both forms of ELE would likely provide similar efficacy, our analysis indicates that WIC ELE has greater political viability given the increasing momentum around this option and projected lower costs (about half that of CalFresh ELE). Additionally, the fact that California allowed CalFresh *Express Lane Enrollment* to phase out in 2017 may indicate that restarting a similar CalFresh ELE program would face political or legal hurdles.

Because The Children’s Partnership’s strategy for the enactment of AB 526 includes developing a “broad advocacy coalition” to develop immigrant support, CIPC is well positioned to support this legislation in a variety of ways.²²⁹ For example, CIPC could (1) persuade its network of progressive organizations to add their names to a letter of support, (2) encourage legislators to champion the bill, (3) provide a forum to discuss ELE at conferences, (4) co-lead policy webinars with The Children’s Partnership, and (5) encourage immigrant communities to call their representatives in support of the proposal.²³⁰ For potential legislative champions, we recommend that CIPC consider contacting Assemblymember Wendy Carrillo (D-Los Angeles) who was formerly undocumented and has long been a champion of immigrant rights, as well as State Senator Scott Wiener (D-San Francisco and San Mateo) who has supported legislation to strengthen social safety nets and currently serves as Assistant Majority Whip.²³¹

As the most expensive policy option 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.²³² Moreover, the financial benefit to the state of providing health insurance for over 100,000 vulnerable women, infants, and children outweighs the costs of the program (further discussed in the following chapter).

228 “Assembly Bill 2579,” Bill Text.

229 Mike Odeh (Director, Health Policy, Children Now), email message to an author, March 11, 2019.

230 Nancy C. Roberts and Paula J. King, “The Actions Behind the Headlines,” chapter in *Transforming Public Policy: Dynamics of Policy Entrepreneurship and Innovation*, San Francisco: Jossey-Bass, 1996, pp. 67-91.

231 “Biography,” Official Website - Assemblymember Wendy Carrillo Representing the 51st California Assembly District, December 4, 2018, <https://a51.asmdc.org/biography>.
Wendy Carrillo, “Home,” Wendy Carrillo for Assembly, accessed March 9, 2019, <https://wendyforassembly.com/>. “Committees,” Senator Scott Wiener (California State Senate Democratic Caucus, February 21, 2019), <https://sd11.senate.ca.gov/committees>. “Legislation,” Senator Scott Wiener (California State Senate Democratic Caucus, February 27, 2019), <https://sd11.senate.ca.gov/legislation>.

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

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 county culture that values the status quo makes RTED a non-viable option at this time.²³³ 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 has the best mission alignment with CIPC and 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.²³⁴ Furthermore, there are many other potential benefits to naturalization, including economic mobility, reduced fear, and expanded civic participation, that would increase the number of immigrant-friendly voters.²³⁵ Therefore, CIPC may be interested in using our analysis to pursue a naturalization campaign focused on sending eligibility notices but for reasons outside the scope of this report.

Table 3. Summary of Policy Evaluation

Criterion	Naturalization	Real-Time Eligibility Determination	Express Lane Eligibility
Efficacy	5,000 to 17,000	41,000 to 105,000	A. WIC: 154,000 B. CalFresh: 143,000
Cost of Implementation <i>Adjusted for inflation</i>	Donations: \$15M to \$47M Fully funded: \$23M to \$70M	A. Increase Reliance on CalHEERS: \$363,000 B. Upgrade SAWS: \$1M	A. WIC: \$104M B. CalFresh: \$224M
Cost-Effectiveness Ratio	Donations: \$1,458/person Fully funded: \$2,178/person	A. Increase Reliance on CalHEERS: \$3 to \$9/person B. Upgrade SAWS: \$10 to \$24/person	A. WIC: \$675/person B. CalFresh: \$1,560/person
Political Feasibility	High	A. Increase Reliance on CalHEERS: Low B. Upgrade SAWS: Low	A. WIC: Medium B. CalFresh: Low

²³³ Steve Wallace (professor, UCLA), in discussion with an author, Los Angeles, CA, December, 20, 2018.

Almas Sayeed (Deputy Director of Programs, California Immigrant Policy Center), in discussion with an author, Los Angeles, CA, January 10, 2019.

Adam Barsch (Program Specialist, Arapahoe County Human Services), email message to an author, February 23, 2019.

²³⁴ Hainmueller et al., "Randomized Controlled Design," 939-44.

²³⁵ Sumption and Flamm, "Value of Citizenship."

CHAPTER 8 DISCUSSION

The California Immigrant Policy Center (CIPC) has the experience, organizational infrastructure, and capability to mitigate the harm of the potentially severe consequences of the expansion of the public charge rule. Given our analysis, we anticipate that any of the policy options we evaluated would create a substantial reduction in the negative health and economic consequences of the proposed change (see Appendix K for a summary of these improvements for all policy options analyzed).

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 4.²³⁶ 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.

²³⁶ As previously noted in Chapter 6, 4,000 mothers are expected to newly enroll in Medi-Cal and 15% of 242,200 dually enrolled mothers, or 36,330 adult women, will be diverted from disenrolling. Adding these together, Medi-Cal enrollment will be improved by a total of 40,000 adult women. Additionally, one adult life is saved for every 239 to 316 non-elderly adults who gain Medicaid coverage, resulting in 128 to 169 adult lives saved each year.

UCLA Center for Health Policy Research, AskCHIS 2017, Adults in households that received WIC benefits in the past year, Gender, Citizenship and Immigration Status, Family Type, Type of current health insurance coverage, http://ask.chis.ucla.edu/AskCHIS/tools/_layouts/AskChisTool/home.aspx#/results, accessed February 10, 2019.

Center for Health Policy Research, AskCHIS 2015-2016 pooled data, Adults in households that received WIC benefits in the past year, Gender, Citizenship and Immigration Status, Family Type, Type of current health insurance coverage. Sommers et al., "Health Insurance Coverage."

Sommers, "State Medicaid Expansions and Mortality, Revisited."

Table 4. Predicted Improvements in the Health and Economic Consequences of the Proposed Public Charge Rule Due to WIC ELE*

Impact	No Intervention	With WIC ELE	Impact of WIC ELE*
Efficacy	317,000 <i>disenrollees</i> (104,000 adults)	163,000 <i>disenrollees</i> (64,000 adults)	154,000 <i>diverted from disenrollment</i> (40,000 adults)
Mortality	329 – 435 adult lives <i>lost</i> annually	203 – 268 adult lives <i>lost</i> annually	128 – 169 adult lives <i>saved</i> annually
Federal Funding¹	\$510M <i>lost</i>	\$103M <i>lost</i>	\$247M <i>saved</i>
Jobs	5,700 jobs <i>lost</i>	2,900 jobs <i>lost</i>	2,800 jobs <i>saved</i>
Economic Output	\$890M <i>lost</i>	\$458M <i>lost</i>	\$432M <i>saved</i>
Taxable Revenue	\$45M <i>lost</i>	\$23M <i>lost</i>	\$22M <i>saved</i>

*All numbers have been rounded

$$\text{Impact of WIC ELE} = (\text{No Intervention}) - (\text{With WIC ELE})$$

Because real-time eligibility determination (RTED) and a naturalization campaign have lower predicted efficacies than ELE, our projected health and economic improvements for these policy alternatives are also less significant than for ELE. That said, we likely underestimate the improved economic impacts of naturalization because we limit our analysis to the consequences of reduced federal Medi-Cal funding without accounting for expected increases in economic mobility due to improved naturalization rates.²³⁷ Of note, both ELE and RTED likely provide even greater health and economic benefits for all Californians than we predict, as thousands more outside the chilled population will be able to enroll in and renew Medi-Cal more easily. In fact, neither ELE nor RTED specifically targets immigrant families. Instead, they are “rising tides lift all boats” approaches that help low-income families in general, which can potentially generate a broader coalition of supporters. Finally, we caution against interpreting our estimates as exact given our reliance on self-reported data from the California Health Interview Survey (CHIS) and our reliance on studies from other states that may not generalize to California.²³⁸

Next Steps

There are many areas for further research that could help inform CIPC’s approach to mitigating the impact of the expansion of public charge. Our report does not consider racial and ethnic subgroup differences in behavior due to a lack of available data, which would help in planning outreach to different immigrant communities. Moreover, while our analysis may shine a light on how programs other than Medi-Cal will be affected, there is much need for

²³⁷ Sumption and Flamm, “Value of Citizenship.”

²³⁸ Center for Health Policy Research, “UCLA Center.”

Wishner, et al., “Medicaid Real-Time.”

Hainmueller et al., “Randomized Controlled Design.”

investigating the impact of public charge on other public benefits programs, such as those that offer housing and food support. Finally, while we only thoroughly evaluated three of the 25 identified policy options, several options were promising but had insufficient data available for a thorough evaluation within the confines of this report. Some of these include:

Reducing fear through curbing immigration consulting by “notarios”

Initially, this option seemed encouraging because it could prevent “notarios” from spreading misinformation to immigrant families and thus reduce the fear that could prompt disenrollment.²³⁹ However, we could not predict its impact on efficacy. It also appeared to lack political feasibility given that AB 638 (Caballero, D-Salinas; Gonzalez, D-San Diego), which would have accomplished this option, failed in the Democratic-led California Senate in 2018 by a large margin.²⁴⁰

Placing more structural or legal barriers between healthcare providers and the federal government (e.g., technological firewalls or policies prohibiting data-sharing with immigration officials)

A prominent immigrant health researcher noted that immigrant patients in a recent pilot study trusted clinic staff to protect their data but were afraid that government officials might hack the clinic’s computer systems or force clinic staff to provide computer access to obtain patient information.²⁴¹ Thus, reassuring patients by protecting their electronic data through technological or legal means appeared to be a potential way to remind them that using clinic services is safe. However, without conducting our own focus groups and patient surveys with large representative samples, we were unable to generate any predictions regarding the efficacy of this policy option.

Training Medi-Cal administrators to counsel beneficiaries

This option would target chilled people who try to actively disenroll mid-cycle. Benefits offices can ask Medi-Cal participants why they want to disenroll. If they describe immigration-related concerns, benefits administrators can then provide basic education, reassurance, and legal referrals to help convince callers to stay enrolled without being coercive. It is crucial to equip staff members with the knowledge and skills to provide accurate, practical advice. Despite this option’s promise, we were unable to assess its efficacy or cost.

239 Alejandra Molina, “California Could Abolish the Immigration-Consultant Industry to Prevent Fraud,” *The Press-Enterprise*, July 14, 2017, <https://www.pe.com/2017/07/13/california-could-abolish-the-immigration-consultant-industry-to-prevent-fraud/>.

240 There were 13 “yes” votes, 17 “no” votes, and 10 abstentions. According to Joseph Villela, Sacramento Democrats defeated AB 638 due to pressure from the immigration consulting, or “notario” community, as many of these individuals and businesses make up part of Sacramento Democrats’ constituencies. “AB-638 Immigration Consultants,” bill, California Legislative Information § (2018), https://leginfo.ca.gov/faces/billVotesClient.xhtml?bill_id=201720180AB638. National Notary Association Staff, “CA Immigration Consultants Saved As AB 638 Fails In State Senate Vote,” *National Notary Association*, September 5, 2018, <https://www.nationalnotary.org/notary-bulletin/blog/2018/09/ca-immigration-consultants-ab-638-fails>. Joseph Villela (Director of Policy, Coalition for Humane Immigrant Rights), in discussion with an author, January 11, 2019. Molina, “Immigration-Consultant Industry.” Eric Schattl (supervising attorney, Health Consumer Center at Neighborhood Legal Services of Los Angeles), in discussion with an author, January 8, 2019.

241 Steve Wallace (professor, UCLA), in discussion with an author, Los Angeles, CA, December, 20, 2018

CHAPTER 9 CONCLUSION

In analyzing how the California Immigrant Policy Center (CIPC) can best mitigate the adverse effects of Medi-Cal disenrollment due to the Department of Homeland Security's (DHS) proposed expanded definition of public charge, we determined that successful policy options would need to reduce fear or improve Medi-Cal uptake or retention.²⁴² We evaluated three promising policy options addressing these issues (a naturalization campaign, real-time eligibility determination (RTED), and Express Lane Eligibility (ELE)) and concluded that ELE based on enrollment in the Special Supplemental Program for Women, Infants, and Children (WIC) is the most sensible option due to its efficacy.

While our recommendation may help mitigate the impacts of an expanded definition of public charge, it may be even more effective to look upstream at the causes of uncertainty facing immigrant families. Because the expanded definition was proposed by DHS under the Trump administration and not through an act of Congress, undoing the rule change would require a similar process.²⁴³ Consequently, electing another president in the 2020 election who is willing to undo the proposed change would also mitigate the problems created by the rule's expansion. Moreover, electing members of Congress who could codify immigrant-friendly protections into law could be an even more permanent solution to shield immigrants from future administrations' potentially harmful policies. While these efforts do not necessarily keep people enrolled in Medi-Cal, they can begin the process of restoring immigrants' confidence and trust in utilizing public assistance programs.

In the event that the 2020 election reinforces support for the current administration's approach to immigration policy, our recommendation could shield families indefinitely unless the federal government rescinds ELE or changes eligibility requirements for WIC or Medicaid. Consequently, targeted voter registration and engagement could be pivotal in uplifting immigrant families given the upcoming election season. In its advocacy efforts, CIPC can move forward with an evidence-based response to the proposed expansion of the public charge rule, reaffirming its status as a "premiere immigrant rights institution" in California.²⁴⁴

242 Batalova, Fix, and Greenberg, "Chilling Effects."
Sommers, "Millions of Children."
Sommers, "Loss of Health Insurance."

243 Inadmissibility on Public Charge Grounds, 83 Fed. Reg. § 196.

244 California Immigrant Policy Center, "About Us."

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AB-638 Immigration Consultants. Bill, California Legislative Information § (2018). https://leginfo.legislature.ca.gov/faces/billVotesClient.xhtml?bill_id=201720180AB638.

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APPENDICES

Appendix A: Details of the Proposed Public Charge Rule

Factors Considered for the “Totality of Circumstances” Aspect of the Public Charge Rule ²⁴⁵

Positively Weighted Factors	Negatively Weighted Factors
<ul style="list-style-type: none"> ▶ Financial <ul style="list-style-type: none"> » 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 <ul style="list-style-type: none"> » Occupational skills, certifications, or licenses » Work authorization and current employment with income of at least 250% FPL 	<ul style="list-style-type: none"> ▶ Financial <ul style="list-style-type: none"> » Income below 125% FPL » Family size compared to assets and resources ▶ Employment <ul style="list-style-type: none"> » Have work authorization and not a full-time student, but is unemployed with no employment history or prospects for future employment ▶ Education <ul style="list-style-type: none"> » 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 <ul style="list-style-type: none"> » 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 ²⁴⁶

- 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

²⁴⁵ Batalova, Fix, and Greenberg, “Chilling Effects.”
Capps et al., “Gauging the Impact.”

²⁴⁶ Capps et al., “Gauging the Impact.”

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.²⁴⁷

Program	Description	Immigration Status ²⁴⁹	Income & Assets	Age
Medi-Cal ²⁵⁰	Medical insurance for low-income adults, children, and women who are pregnant	<u>Full-Scope</u> : All children eligible <u>Restricted</u> : All eligible	Less than 138% FPL	Below 64
Medicare Part D Low Income Subsidy ²⁵¹	Covers prescription drugs for low-income seniors enrolled in Medicare	<u>LPR</u> : At least 5 years residency	<u>Full</u> : Less than 135% FPL <u>Partial</u> : 135% to 150% FPL	Over 65
Institutionalization for Long-Term Care ²⁵²	Nursing home; convalescent care; preventive, primary, and specialty care services	<u>Emergency Services</u> : All eligible	<u>Income</u> : No limit (patient); Can keep \$3,023 per month (spouse) <u>Assets</u> : Less than \$2,000 (patient); less than \$120,900 (spouse)	<u>Psychiatric</u> : Under 21 <u>Mental Health</u> : Over 65
SNAP (CalFresh) ²⁵³	Nutrition assistance for low-income families and individuals (“food stamps”)	<u>LPR</u> : At least 5 years residency + 40 quarters of work	Less than 200% FPL	Below 18
Public Housing ²⁵⁴	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 ²⁵⁵	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

247 “Major Benefit Programs Available to Immigrants in California,” National Immigration Law Center, May 2017, <https://www.nilc.org/issues/economic-support/programs-available-to-immigrants-in-calif/>.

248 “Major Benefit Programs Available to Immigrants in California,” National Immigration Law Center, May 2017, <https://www.nilc.org/issues/economic-support/programs-available-to-immigrants-in-calif/>.

249 “Major Benefit Programs Available to Immigrants in California,” National Immigration Law Center.

250 “Medi-Cal,” HIPAA Title Information, September 27, 2018, <https://www.dhcs.ca.gov/services/medi-cal/pages/doyouqualifyforme-di-cal.aspx>.

251 Centers for Medicare & Medicaid Services, “Eligibility for Low Income Subsidy,” CMS.gov, March 26, 2012, <https://www.cms.gov/Medicare/Eligibility-and-Enrollment/LowIncSubMedicarePresCov/EligibilityforLowIncomeSubsidy.html>.

252 “Los Angeles County Department of Public Social Services,” County of Los Angeles DPSS - Home, 2019, http://dpss.lacounty.gov/wps/portal/dpss/main/programs-and-services/health-care/seniors-disabilities/long-term-care-medi-cal!/ut/p/b0/04_Sj9CPyksy0xPLMnMz0vMAfGjzOLDdAwM3P2dgo0MXM0cDRz9g70MQy28DR3dTPULsh0VAQJ4yaY!.
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253 Food and Nutrition Service. “Supplemental Nutrition Assistance Program (SNAP),” April 25, 2018, <https://www.fns.usda.gov/snap/supplemental-nutrition-assistance-program-snap>.

254 U.S. Department of Housing and Urban Development, “Hud’s Public Housing Program.” HUD.gov / U.S. Department of Housing and Urban Development (HUD), 2019, https://www.hud.gov/topics/rental_assistance/phprog.

255 U.S. Department of Housing and Urban Development, “Housing Choice Vouchers Fact Sheet.” HUD.gov / U.S. Department of Housing and Urban Development (HUD), 2019. https://www.hud.gov/topics/housing_choice_voucher_program_section_8.
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Program	Description	Immigration Status ²⁴⁹	Income & Assets	Age
TANF (CalWorks) ²⁵⁶	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 ²⁵⁷	N/A
SSI ²⁵⁸	Monthly cash assistance to low-income people, the disabled, blind, or elderly	<u>LPR</u> : At least 5 years residency + 40 quarters of work <u>Refugee/Asylee</u> : At least 7 years residency	<u>Income</u> : Less than \$750/month <u>Assets</u> : 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) ²⁴⁹	State program providing financial assistance to those who meet all eligibility criteria for SSI other than immigration status	All eligible	<u>Income</u> : Less than \$750/month <u>Assets</u> : Less than \$2000 (single) or less than \$3,000 (married couple)	65 and over Children who are blind or disabled

256 "Benefits & Services," CDSS Public Site, 2019, <http://www.cdss.ca.gov/CalWORKS>.

257 "Benefits & Services," CDSS Public Site.

258 Social Security Administration, "Understanding Supplemental Security Income (SSI)-- SSI Eligibility," Reports, Facts and Figures | Press Office (2019), <https://www.ssa.gov/ssi/text-eligibility-ussi.htm>.

259 "Benefits & Services," CDSS Public Site, 2019, <http://www.cdss.ca.gov/CAPI>.

Appendix C: Estimates of the Chilled Population²⁶⁰

Study	Population	Dataset	Estimated Total Population
Migration Policy Institute June 2018	Immigrants in a household where a member used a public benefit (Medicaid/CHIP, SNAP, SSI, TANF) in U.S. + U.S.-born children in families where an immigrant member used a benefit	2014-16 American Community Survey	26.9 million (US)
Fiscal Policy Institute October 2018	Adults and children living in a family with a noncitizen in U.S. and received at least one public benefit	2013-15 Current Population Survey	24 million (US) 6 million (CA)
Kaiser Family Foundation October 2018	Individuals in a household with a noncitizen in U.S. and enrolled in Medicaid/CHIP	2014 Survey of Income and Program Participation	14 million (US)
Manatt²⁶¹ October 2018	All noncitizens and their dependents	2012-2016 American Community Survey	22.1 million noncitizens or 41.1 million noncitizens and their family members (US)

²⁶⁰ Table Adapted From Ninez Ponce, Laura Lucia, and Tia Shimada, "Proposed Changes".

²⁶¹ "Public Charge Proposed Rule: Potentially Chilled Population Data Dashboard." Manatt, October 11, 2018. <https://www.manatt.com/insights/articles/2018/public-charge-rule-potentially-chilled-population>.

Appendix D: Chilled Population by Age and Race/Ethnicity²⁶²

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%

²⁶² Ponce, Lucia, and Shimada, "Proposed Changes," Lecture.
Ponce, Lucia, and Shimada, "Proposed Changes: Data Tables," 2-3.

Appendix E: Regional Disenrollment and Economic Impact Predictions²⁶³

Region	15% Predicted Disenrollment*	Loss in Federal Medi-Cal Funding*	Job Loss*	Economic Output Loss**
California Statewide	317,000	\$ 510 million	5,700	\$ 890 million
Bay Area	42,000	\$ 67 million	600	\$ 118 million
Central Coast	20,000	\$ 33 million	400	\$ 54 million
Los Angeles County	106,000	\$ 174 million	2,000	\$ 310 million
Northern and Sierra Region	6,000	\$ 9 million	100	\$ 13 million
Other Southern California Region	80,000	\$ 124 million	1,500	\$ 225 million
Sacramento Region	9,000	\$ 14 million	200	\$ 26 million
San Joaquin Valley	54,000	\$ 87 million	100	\$ 141 million

*Disenrollment rounded to the nearest thousand; loss federal funding rounded to nearest million; job loss rounded to the nearest 100 jobs; economic output loss rounded to nearest million

**The average per person dollar amount received from the federal government for Medi-Cal used in the analysis are \$451 per month for ACA Expansion adults, \$164 for children enrolled in CHIP, and \$220 for all other adults.²⁶⁴ The average cost per person CHPR uses is an underestimate of the true costs because it does not include the extra funding required for people in "aged or disabled aid codes" that have higher per person costs because estimating the population within those aid codes is difficult.²⁶⁵ These people are included in the analysis, but are calculated using the average per person cost.²⁶⁶

²⁶³ Table adapted from Ponce, Lucia, and Shimada, "Proposed Changes," 5-7.

²⁶⁴ Ponce, Lucia, and Shimada, "Proposed Changes," 3.

²⁶⁵ Ibid.

²⁶⁶ Ibid.

Appendix F: Semi-Structured Interview Questions

1. How do you think public charge is going to impact communities, the county/state, hospitals, companies, etc.?
2. What policies have you heard being considered to ensure that eligible immigrants and their family members stay enrolled in programs?
 - a. Which of these seem most/least feasible (politically, logistically, financially, etc.)?
 - b. What are potential intervention points for these policies?
 - c. What strengths/barriers do you see for these policies being adopted?
3. What policies/strategies have worked/failed in the past to improve program enrollment for vulnerable communities?
4. Who, if anyone, do you think has the power and/or desire to address this issue?
5. What gaps in research are there, i.e. what do you still need to know that would be helpful for your goals?

Appendix G: Political Feasibility Survey

Consider the following state level policy options:

1. FUNDING FOR A NATURALIZATION CAMPAIGN

California currently has 2.2 million adults who are eligible to naturalize and gain citizenship. Since FY 2015-2016, the state of California has funded naturalization and other immigrant integration services through local direct service providers who currently work in silos. This policy option would establish and fund a new statewide program that would notify residents of their eligibility to naturalize and eligibility for application fee waivers; coordinate efforts among existing and new direct service providers to help residents naturalize; provide a clearinghouse for direct service providers to share and distribute resources to residents across the state; and advertise the availability of naturalization services broadly.

The following two options are designed to address difficulties with enrollment and renewal processes, which are frequently cited as reasons for not having public health insurance.

2. REAL-TIME ELIGIBILITY VERIFICATIONS FOR MEDI-CAL WITH AUTO-RENEWALS

Currently, applicants can enroll in Medi-Cal through Covered California's website, which uses a statewide system called CalHEERS to determine eligibility within 10-15 seconds for enrollments and subsequent annual renewals. Still, 79% of applicants apply through county-based systems (Statewide Automated Welfare Systems - SAWS) that do not yet offer real-time eligibility verification and have limited auto-renewal capabilities. This policy option would require counties to increase real-time eligibility verifications and auto-renewals through greater reliance on CalHEERS, upgrading SAWS, or an improved interface between the two systems.²⁶⁷ It would also provide funding to make necessary systems upgrades.

3. EXPRESS LANE ELIGIBILITY (ELE)

ELE is a provision that allows enrollment data for public benefits programs (e.g. WIC - food assistance for children and pregnant/breastfeeding women, CalFresh - food stamps, school free/reduced lunch program, etc.) to be used to automatically enroll uninsured individuals in Medi-Cal. When participants enrolled in Medi-Cal and an additional qualifying public benefits program are due for annual Medi-Cal renewal, their enrollment in the other public benefits program can also be used to verify Medi-Cal eligibility and automatically renew their Medi-Cal coverage for another year. Currently, no ELE option exists in the state of California although it has been used in the past. This policy option would authorize and fund ELE so that enrollment in one or more designated public benefits programs could be used to auto-enroll and auto-renew participants in Medi-Cal.

Scoring Individual Policy Options

Assuming that all policy options were to cost the state \$30 million for one year and taking the current political context into consideration, rate the political feasibility of codifying each policy option into law within the next two years using the following scale:

- 1 = Little to no chance of passage due to lack of support from MOST governing bodies and stakeholders
- 2 = Likely to fail despite support from SOME governing bodies and/or stakeholders
- 3 = Likely to pass but could face significant challenges from SOME governing bodies and/or stakeholders
- 4 = Expected to pass with minimal to no resistance from MOST governing bodies and/or stakeholders

²⁶⁷ We ultimately discarded the interface mechanism following distribution of this survey due to a lack of information about possible costs and whether this was technically possible.

You may assign the same feasibility score to as many policy options as you'd like (e.g. all three options could be considered "1 - lowest feasibility").

Policy Options *

	1 - Lowest feasibility	2	3	4 - Highest feasibility
Naturalization campaign	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Real-time eligibility verification with auto-renewals	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Express lane eligibility	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Ranking Policy Options

Again, assuming that all policy options were to cost the state \$20 million for one year and taking into consideration the current political context, rank the following policy options from MOST to LEAST politically feasible over the next two years.

No more than one policy option may be assigned to each level of feasibility (e.g. no two options can be "most feasible").

	Least feasible	Medium feasibility	Most feasible
Naturalization campaign	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Real-time eligibility verification with auto-renewals	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Express lane eligibility	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Appendix H: CHIS Questionnaire Text and Instructions, 2015-2017²⁶⁸

DEMOGRAPHICS

'QA17_A1' [AA1] - What is your date of birth?

'QA15_A5' [A] - Are you male or female?

QA15_K4 - What is your best estimate of all your earnings last month before taxes and other deductions from all jobs and businesses, including hourly wages, salaries, tips and commissions?

Family Type (*description from AskCHIS help box*): This variable was created with information about the households surveyed. For people who are currently married but do not live with their spouses, their family type is listed as Single. **Corresponding source variable(s): FAMT4**

'QA17_I76' [AI60] - About how many years has (TEEN)'s {mother/father} lived in the United States?

QC18_H12' [CH10] - About how many years have you [adolescent/child] lived in the United States? This variable is not asked of everyone: Asked of respondents who were born outside of the U.S.

'QA17_G9' [AH39] - The next questions are about citizenship and immigration. Are you a citizen of the United States?

'QA17_G10' [AH40] - Are you a permanent resident with a green card? Your answers are confidential and will not be reported to Immigration Services. [IF NEEDED, SAY: "People usually call this a "Green Card" but the color can also be pink, blue, or white."]

²⁶⁸ "UCLA Center for Health Policy Research," Search Press Releases | UCLA Center for Health Policy Research, 2019, <http://healthpolicy.ucla.edu/chis/design/Pages/questionnairesEnglish.aspx>.

PUBLIC BENEFITS UTILIZATION

Type of Health Care Coverage in the Past 9 months (*description from AskCHIS help box*): This variable was constructed from a variety of source variables, to provide an all-encompassing look at type of coverage for all children and adults, including those 65 years and older. It provides more granular information for the population covered by employer-based insurance (whether alone or in combination with Medicare or Medicaid). **Corresponding source variable: INSTYPE**

'QA17_H16' [A16] - **{Is it correct that you are/Are you} covered by Medi-CAL?**
[IF NEEDED, SAY: "A plan for certain low-income children and their families, pregnant women, and disabled or elderly people."]

Eligibility of Uninsured under 65 for Medi-Cal (MAGI Guidelines) (*description from AskCHIS help box*): Constructed from revised Medi-Cal eligibility criteria based on Modified Adjusted Gross Income, effective Jan. 2014; caution trending w/ 2013 and prior Medi-Cal eligibility. This eligibility estimate is based on questions in CHIS 2013-14 designed to reflect the eligibility criteria in these programs. This variable was created using age, insurance, family type, monthly income, and citizenship information. This variable is not asked of everyone: Asked of respondents who are uninsured and are under 65 years of age. **Corresponding source variable: ELGMAGI3**

'QA17_L32' [AL49] - **During the past 12 months, did you or any member of your household receive benefits from the WIC program, that is, the Special Supplemental Nutrition Program for Women, Infants and Children?** This variable is not asked of everyone: Asked of individuals with household incomes below 301% FPLs who are currently pregnant or in households with women under 46 years or children under 11 years.

QC18_E2 [CE11A] - **Are you [Child] receiving Food Stamp benefits?** This variable is not asked of everyone: Asked of all people in a household with total annual household income less than 300% of the Federal Poverty Level.

QA15_L4 - **Is (TEEN) receiving Food Stamp benefits, also known as CalFresh?** [IF NEEDED, SAY: "You may receive benefits as stamps or through an EBT card." EBT stands for Electronic Benefit Transfer card and is also known as the Golden State Advantage Card]

QA15_L3 - (Adult) **Are you receiving Food Stamp benefits, also known as CalFresh?** [IF NEEDED, SAY: "You receive benefits through an EBT card." EBT stands for Electronic Benefit Transfer card and is also known as the Golden State Advantage Car

Appendix I: 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.

Appendix J: Naturalization Efficacy Methodology

Step One: Are CSII estimates and predictions reasonably accurate for California?

The Center for the Study of Immigrant Integration (CSII) predicts that on average, 15.7% of all Americans eligible to naturalize (ETNs) will do so over two years.²⁶⁹ This means that 335,886 of the estimated 2,239,237 ETNs in California would naturalize over two years, or 167,943 over one year. This is 7% higher than the actual number of people who naturalized in 2017 (157,364).²⁷⁰ However, CSII also estimates that California has a higher proportion of ETNs with a low probability of naturalization than the national average (47.8% vs. 39.7%, respectively).²⁷¹ Therefore, we feel that CSII's predictions are a reliable foundation for our efficacy estimates.

Step Two: How many ETNs are on Medi-Cal?

The Center for Health Policy Research (CHPR) only counts those who receive federally funded full-scope Medi-Cal as part of the chilled population.²⁷² Because of eligibility requirements, this limits the CHPR *adult* chilled population to (1) Legal Permanent Residents (LPRs) with at least five years of residency and (2) LPRs with less than five years of residency who are pregnant or veterans/active duty military.²⁷³ Because only adult LPRs with at least five years of residency are eligible to naturalize, CHPR's adult chilled population consists almost exclusively of ETNs (we assume that the number of pregnant or veteran/active duty military LPRs with less than five years of residency is a small number, but this does make our prediction a slight overestimate). Thus, we use CHPR's estimate of the number of **adult chilled people enrolled in Medi-Cal (i.e. 693,000) to estimate the number of ETNs enrolled in Medi-Cal.**²⁷⁴

Step Three: What percentage of fee waiver-eligible ETNs are on Medi-Cal?

To qualify for a fee waiver, ETNs must have an income below 150% of the Federal Poverty Level (FPL) or be enrolled in a public benefit like Medicaid.²⁷⁵ Because there are an estimated 738,978 fee waiver-eligible ETNs and 693,000 ETNs on Medi-Cal (who are all fee waiver-eligible), an estimated **93.7% of fee waiver-eligible ETNs are enrolled in Medi-Cal.**²⁷⁶

Step Four: How many fee waiver-eligible ETNs on Medi-Cal would normally naturalize over two years without any intervention?²⁷⁷

There are 738,978 ETNs in CA with incomes under 150% FPL.²⁷⁸ CSII assigns the following range of naturalization probabilities to each group, with the cutoffs for low and high probability being half a standard deviation away from the average:²⁷⁹

- Low = 0 to 9.7%; n = 438,468
- Medium = 9.7 to 21.7%; n = 208,398
- High = over 21.7%; n = 76,610

269 Permission was granted by CSII to use their probability of naturalization maps and report in our analysis. All instances of their research have been properly credited within this report.
USC, *Interactive Map*.

270 Department of Homeland Security, "Table 22. Persons Naturalized by State or Territory of Residence: Fiscal Years 2015 to 2017," Department of Homeland Security, October 2, 2018, <https://www.dhs.gov/immigration-statistics/yearbook/2017/table22>.

271 Le, et al. "Paths to Citizenship," 35.

272 Ponce, Lucia, and Shimada, "Proposed Changes," 2.

273 Ibid.

274 Ponce, Lucia, and Shimada, "Proposed Changes," Lecture, 31.

275 USCIS, "Fee Waiver."

276 USC, *Interactive Map*.

Ponce, Lucia, and Shimada, "Proposed Changes," Lecture, 31.

277 Manuel Pastor et al., *Paths to Citizenship: Data on the Eligible-to-Naturalize Populations in the U.S.*, January 2019, https://dornsife.usc.edu/assets/sites/731/docs/CSII_NAC_Webinar_January2019.pdf, 16.
USC, *Interactive Map*.

278 Rounding errors cause the sum to be less than the total number of ETNs with incomes under 150% FPL.
Ibid.

279 Ibid.

If we assume the lowest probability of naturalization for each group (i.e. 0%, 9.7%, and 21.7%), the usual number of people under 150% FPL who would naturalize over two years is **36,839**.

- Low: 0% of 438,468 = 0
- Medium: 9.7% of 208,398 = 20,215
- High: 21.7% of 76,610 = 16,624
- **Total:** 0 + 20,215 + 16,624 = 36,839

If we assume the highest rate of naturalization for each group, then the usual number of people who would naturalize over two years is **113,571**.

- Low: 9.7% of 438,468 = 42,531
- Medium: 21.7% of 208,398 = 45,222
- High: 33.7% of 76,610 (1 standard deviation above the average) = 25,818
- **Total:** 42,531 + 45,222 + 25,818 = 113,571

Thus, CSII predicts that 36,839 to 113,571 fee waiver-eligible ETNs in California will naturalize over two years.²⁸⁰ Assuming a 93.7% Medi-Cal participation rate for this group from Step Two, **34,518 to 106,416 fee waiver-eligible ETNs on Medi-Cal will naturalize over two years.**

Step Five: How do Californians compare to New Yorkers?

In 2017, Californians naturalized at a lower rate compared to New Yorkers (7.0% vs 9.8%), indicating that Californians might not be as responsive to fee waiver eligibility notifications as New York City residents.²⁸¹ However, recent news reports note that naturalization application rates have swelled under the Trump administration, indicating that ETNs are generally more likely to apply for naturalization than before.²⁸² Thus, we assume that Californians will now respond as well as New Yorkers did to fee waiver eligibility notices in Summer 2016 and be 35% more likely to submit naturalization applications after receiving such a notice.²⁸³

Step Six: What is the impact of financial assistance on Medi-Cal disenrollment?

If the naturalization rate increases by 35% amongst fee waiver-eligible ETNs on Medi-Cal, then an extra 12,081 to 37,245 people with incomes under 150% FPL will naturalize in two years, for a total of 46,599 to 143,661 people.²⁸⁴ If 15% of the new naturalizers (i.e. 15% of 12,081 to 37,245 people) would have otherwise disenrolled from Medi-Cal, 1,812 to 5,586 adults are saved from disenrolling.²⁸⁵ If each of these adults has 2 dependents who would have also disenrolled, then **5,436 to 16,758 chilled adults and children would be saved from disenrolling by financial assistance with naturalization.**²⁸⁶

²⁸⁰ USC, *Interactive Map*.

²⁸¹ Department of Homeland Security, "Persons Naturalized by State." USC, *Interactive Map*.

²⁸² Jordan, "Wait Times for Citizenship."

²⁸³ Hotard et al., "Nudge Increases Citizenship Application Rates."

²⁸⁴ Ibid.

Ponce, Lucia, and Shimada, "Proposed Changes," Lecture, 31.

²⁸⁵ Ibid.

²⁸⁶ Ponce, Lucia, and Shimada, "Proposed Changes: Data Tables," 2-3.

Appendix K: Predicted Improvements in the Health and Economic Consequences of the Proposed Public Charge Rule*

	No Intervention	Naturalization	RTED - Upgrade SAWS	ELE - WIC
Efficacy ²⁸⁷	317,000 disenrollees (104,000 adults)	5,000 – 17,000 (2,000 – 6,000 adults)	41,000 – 105,000 (14,000 – 35,000 adults)	154,000 (40,000 adults)
Mortality ²⁸⁸ <i>Adult lives saved annually</i>	329 – 435 adult lives lost annually	6 – 25	44 – 146	128 – 169
Federal Funding Saved	\$510M lost (\$1,607/person)	\$8M – \$27M	\$66M – \$169M	\$247M
Jobs Saved	5,700 jobs lost	100 – 300	700 – 1,900	2,800
Improved Economic Output	\$890M lost	\$14M – \$48M	\$115M – \$294M	\$432M
Improvements in Taxable Revenue	\$45M lost	\$1M – \$2M	\$6M – \$15M	\$22M

*All numbers have been rounded

287 In the Medi-Cal chilled population, there are two children for every one adult. Therefore, we assume that 33% of all chilled people who are saved from disenrolling are adults.
Ponce, Lucia, and Shimada, "Proposed Changes," Lecture, 31.

288 For every 239 to 316 adults who gain Medicaid coverage, one adult life is saved each year.
Sommers et al., "Health Insurance Coverage and Health."
Sommers, "State Medicaid Expansions and Mortality, Revisited."