

SPECIAL REPORT

Models And Momentum For Insuring Low-Income, Undocumented Immigrant Children In California

The California Endowment's demonstration project to help an underserved and often-forgotten vulnerable population.

by Janice Frates, Joel Diringier, and Laura Hogan

ABSTRACT: Undocumented immigrant children are an underserved, vulnerable population that has not benefited from the recent expansion of publicly funded children's health insurance programs. The California Endowment funded a two-year demonstration project to provide subsidized health insurance coverage to more than 7,500 children through five nonprofit organizations. Sustaining and promoting coverage for this population will require continuing subsidies through a mix of private and public funding. Locally based, comprehensive initiatives are in place or emerging in a growing list of California counties.

WITH RECENT expansions and reforms, nearly all low-income California children are now eligible for publicly funded health insurance coverage.¹ However, one group continues to be excluded: an estimated 180,000 undocumented immigrant children. These children are predominantly Latino and from very-low-income working families, lack access to employer-sponsored health coverage, and face the highest barriers to care.² Uninsured Latino immigrants generally have poor access to ambulatory and emergency services and are less likely to have a usual source of care.³ Among Latino children ages 6–17 (who are more likely to be undocumented than younger children are), 16 percent have not seen a physician in the past two years, compared

with 7 percent of uninsured white children.⁴

Federal law limits eligibility for federally funded health benefits to "qualified" immigrants with permanent legal residency, except for emergency care.⁵ Although California has provided some additional coverage for undocumented residents for prenatal care and children's health screening, very few states provide coverage for the undocumented.

The California Endowment, one of the nation's largest health care foundations, developed a demonstration project in 2000 to subsidize health coverage for uninsured, low-income, undocumented immigrant children in California. Supporting the endowment's mission to expand access to affordable, high-quality health care for underserved people and communities and to promote fundamental im-

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provements in the health status of all Californians, the project had three main objectives: (1) decrease the number of uninsured children by subsidizing health insurance through nonprofit health organizations throughout the state; (2) study different approaches for providing subsidized coverage to uninsured undocumented immigrant children through a diverse array of grantee organizations; and (3) stimulate further support for covering this population from other entities, both public and private. The endowment has awarded five project grantees a total of \$4.6 million to date, with an additional \$900,000 awarded to the Santa Clara Children's Health Initiative to support a comprehensive countywide organizational effort.

Grantees

The endowment sought diverse types of organizations that could provide coverage within a short time frame and sustain their efforts after foundation funding expired. After conducting an environmental scan of promising nonprofit insurance expansion efforts throughout California, the endowment selected four nonprofit health plans and one nonprofit organization that purchases health coverage for children.

■ **A "quasi-public" health plan: Alameda Alliance for Health.** The alliance, a local health plan in Alameda County, was established in 1996 and serves Medi-Cal, Healthy Families, and commercial members through a provider network that includes both community health centers (CHCs) and private providers.⁶ Since July 2000 the alliance has offered a subsidized individual plan, Family Care, for more than 7,000 low-income adults and children in families with incomes below 300 percent of the federal poverty level. Family Care members receive comprehensive coverage that includes pharmacy, mental health, and dental benefits. Monthly premiums are \$10 per child, with low or no copayments.

To date, the alliance has allocated \$15 million from plan reserves to fund Family Care through 2005. The endowment's grant augmented these efforts by providing subsidies for

about 300 undocumented immigrant children.⁷

■ **A nonprofit provider-based plan: Sharp Health Plan.** Sharp Health Plan, established in 1992, is owned by Sharp HealthCare, a large, nonprofit integrated delivery system in San Diego County. Current plan membership is about 120,000, fairly evenly divided between commercial and government-sponsored enrollees. The provider network includes several CHCs.

Sharp launched FOCUS (Financially Obtainable Coverage for Uninsured San Diegans), a subsidized small-group product for low-wage employees and their dependents (below 300 percent of poverty), in April 1999 with funding from the Alliance Healthcare and California HealthCare Foundations. Employers pay a low fixed monthly premium of \$25 (for a single employee) or \$50 (for family coverage). Employee contributions vary by income and family size from \$10 to \$200 per month, or 1 percent to 4 percent of gross income. Combined foundation subsidies of up to \$175 per subscriber per month cover about half of the total average monthly premium. The benefit package features basic medical services (no dental or vision care) and low copayments. The endowment provided subsidies for approximately 500 children in FOCUS.

Available grant funding limited FOCUS enrollment to about 1,800 enrollees for two years, about a third of whom were dependent children. In its third year FOCUS began moving eligible children to public programs; as of fall 2002 more than half of these children had moved to Medi-Cal or Healthy Families.

■ **A nonprofit integrated delivery system: Kaiser Permanente California (KPC).** KPC is California's oldest and largest health plan, in operation for more than fifty years and serving 6.3 million Californians. In 1998 the Kaiser Permanente Cares for Kids (KPCK) Initiative launched the Child Health Plan (CHP-1), which subsidizes coverage for children with family incomes between 250 and 300 percent of poverty.

The endowment first funded a Kaiser Permanente feasibility study for a program to

cover undocumented children. After Kaiser's board approved funding for this program from the KPCK allocation, additional grants from the endowment funded part of the implementation and evaluation costs for a pilot project for a new subsidized children's health plan. Child Health Plan 2 (CHP-2), the pilot, when fully implemented will serve 5,000 undocumented immigrant children with family incomes below 250 percent of poverty in three heavily Latino communities of southeast Los Angeles County. Benefits include comprehensive medical care and dental coverage, which is not otherwise available through Kaiser. The family pays a \$24 annual enrollment fee; the KPCK initiative pays the rest of the premium. CHP-2 began enrollment in July 2001 and had signed up more than 3,200 children as of September 2002.

A nonprofit community-based plan: Community Health Group (CHG). Founded in 1982 by a CHC one mile north of the U.S.–Mexico border, the CHG has approximately 100,000 members in San Diego County. Most are Medicaid beneficiaries; the rest are in Healthy Families and commercial plans. The CHG is a network-model plan that grew from a base of community clinics and traditional safety-net providers to include private practitioners. The endowment's funding for the CHG's AddKids project was intended to provide coverage for approximately 300 children of low-income workers enrolled in the CHG's small-group commercial plan who were ineligible for public programs. The endowment's grant subsidized \$45 of AddKids' \$55 monthly premium; families paid \$10 per child with a maximum of \$30 per family for comprehensive medical benefits, but no dental or vision coverage.

The CHG experienced serious marketing and enrollment challenges with AddKids, ranging from broker disinterest to crowding-out concerns. Fewer than fifty children enrolled. Recognizing that its model was not viable, the CHG redirected its grant funds to another grantee, California Kids Healthcare Foundation (CalKids), to enroll up to 750 San Diego County children, with about 500 signed up as of October 2002.

Nonprofit purchaser of health coverage:

CalKids. CalKids is a nonprofit organization founded in 1992 that provides coverage for primary, preventive, and emergency care, plus dental, vision, behavioral health, and pharmacy benefits, but no inpatient care. Using foundation and other grants as well as donations, CalKids purchases coverage for approximately 23,000 uninsured, undocumented immigrant children ages 2–18 in families with incomes below 250 percent of poverty at a cost of \$400 per child per year. Endowment grants to CalKids provided direct subsidies for more than 6,000 children, as well as support for fund raising.

Other Participants And Partners

The endowment's demonstration project grantees and partners met quarterly to discuss strategies for sustainability, policy updates, outreach and enrollment programs, new immigrant coverage programs, and evaluation. These meetings grew to include more than thirty organizations that had developed or were considering comprehensive children's coverage initiatives, as well as researchers, policy advocates, and evaluators. They generated fruitful dialogue on immigrant coverage issues and fostered further collaboration on public education and policy advocacy, particularly in promoting initiatives at the county level.

Lessons Learned

The endowment project provided lessons for program, policy, and philanthropic discussions.⁸ Data are available from the five programs that it funded, but they are not comparable because each program has its own membership data collection and reporting systems, and each has a unique structure.

■ **Program lessons.** The rapid enrollment of more than 7,500 low-income, undocumented immigrant children in these subsidized programs reflected a high level of need. All of the endowment grantees, except the CHG, met or exceeded enrollment targets soon after they implemented their programs.

Those and other enrollees in grantees' subsidized products were overwhelmingly Latino, primarily school-age or older, and from lower-

income families. Mixed immigration and employment status was common within families; a typical constellation included older undocumented and younger citizen and legal resident children and one or more working adults. Many families were pursuing legalization.

Many outreach and enrollment activities were crucial to serving the target population effectively. Grantees found that a recommendation from a trusted source was the most effective referral method, and they worked with community organizations that serve immigrant children such as migrant education and Head Start programs, schools, and community providers.

To minimize enrollment barriers, grantees developed short, simple application forms and provided personal assistance in the applicants' languages. They also actively helped families to enroll eligible children in public programs. Providing an "open door" through which all children, regardless of immigration status, could obtain coverage maximized participation in existing public programs. Dental benefits were found to be a strong enrollment incentive in the CalKids, Family Care, and Kaiser subsidized products.

Use of services in the subsidized programs was found to be similar to that of other insurance products, with the exception of dental services, where heavy initial service use indicated pent-up demand. Underuse was a bigger concern for some grantees. After finding in 1999 (before the endowment's project began) that only one-third of Los Angeles children used any physician services in their first six months of enrollment, CalKids began an educational outreach campaign to encourage use of benefits. Kaiser also developed proactive member education and orientation processes and will include a comprehensive analysis of utilization data in its forthcoming evaluation.

Retention problems are commonplace in subsidized health coverage programs. CalKids' member retention rate of 50 percent after twelve months is higher than that for Medi-Cal (37 percent) but lower than that for Healthy Families (75 percent), which raises the question of whether nonusers are less

likely to maintain coverage.⁹ CalKids found that continued outreach and case management are essential to maintaining contact with its highly mobile membership.

Enrollees' source of care is highly dependent on the plan's providers. CalKids and FOCUS evaluation findings indicated some shift from CHCs to private providers after enrollment in these programs. There are not yet sufficient data available from the grantee projects to assess their impact on enrollees' health.

■ **Policy lessons.** Sustaining and promoting coverage for uninsured, undocumented immigrant children will require substantial resources and support from multiple stakeholders. All of the projects discussed here were heavily subsidized. Given the participants' low incomes and the restrictions on public coverage for them, continuing subsidies will be needed to insure this population. Alameda Alliance for Health and KPC have committed large amounts of internal resources to the programs, while grantees rely solely on external sources. A mix of internal and external private and public funding will be necessary to sustain the programs over time.

Initiatives to expand children's health insurance in California are evolving primarily at the county level, through joint efforts involving locally focused health plans and foundations, county health and children's officials, and key stakeholders such as organized labor. Santa Clara and San Francisco have implemented "Healthy Kids" subsidized plans for any children in families with incomes under 300 percent of poverty, and several other counties are developing coverage expansion initiatives that may cover undocumented immigrant children.¹⁰ Funding for county programs has come from a variety of sources, including the Proposition 10 tobacco tax, tobacco settlement funds, local health plan reserves, and private foundations.¹¹

■ **Philanthropic lessons.** Funding partnerships with statewide and local public and private funding sources provided the most sustainable results. The CalKids, FOCUS, and CHG grantees showed that reliance on founda-

tion subsidies augurs poorly for long-term viability. The endowment's grants to Kaiser and Alameda helped them to garner additional resources on a much broader scale.

The quarterly grantee meetings helped organizations with a shared interest in comprehensive children's coverage to coalesce and move forward. Attendance by other stakeholders sparked efforts by groups in other counties working on similar expansion efforts. For instance, participation by Children's Health Initiative from Santa Clara County, which has funded the first county-level effort to declare a commitment to universal children's coverage, stimulated efforts around the state.

Lastly, the endowment understood that subsidies for health coverage alone would not guarantee access to care for this population. While this project involved subsidizing health insurance coverage for more than 7,500 of California's approximately 180,000 uninsured, undocumented immigrant children, the endowment also continued and expanded its ongoing grant programs for safety-net providers, such as CHCs.

THE CURRENT economic downturn and the resulting state budget shortfalls have halted recent progress in the expansion of publicly funded health insurance programs in California and in many other states.¹² Yet a burgeoning group of California counties continues to pursue the goal of providing health insurance coverage for all low-income uninsured children without regard to residency status. Both local community and private-sector organizations will be instrumental in the further development and funding of these efforts.

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The authors appreciated the opportunity to learn from and with project grantees and interested partner participants about serving this often ignored and undervalued population, whose contributions continue to enrich and invigorate our society.

NOTES

1. M. Broaddus and L. Ku, *Nearly 95 Percent of Low-Income Uninsured Children Now Are Eligible for Medicaid or SCHIP*, 6 December 2000. www.cbpp.org/12-6-00schip.htm (15 October 2002).
2. E.R. Brown et al., *The State of Health Insurance in California: Findings from the 2001 California Health Interview Survey* (Los Angeles: UCLA Center for Health Policy Research, June 2002).
3. L. Ku and S. Matani, "Left Out: Immigrants' Access to Health Care and Insurance," *Health Affairs* (Jan/Feb 2001): 247-256.
4. G. Flores et al., "The Health of Latino Children: Urgent Priorities, Unanswered Questions, and a Research Agenda," *Journal of the American Medical Association* (3 July 2002): 82-90.
5. R. Capps et al., *How Are Immigrants Faring after Welfare Reform? Preliminary Evidence from Los Angeles and New York City*, 4 March 2002, www.urban.org/UploadedPDF/410426_final_report.pdf (4 November 2002).
6. California's Medicaid program is known as Medi-Cal, and its State Children's Health Insurance Program (SCHIP) as Healthy Families.
7. Children qualified for coverage based on family income and parental self-declaration of the child's ineligibility for public programs. Because the Healthy Families family income limit is 250 percent of poverty and Medi-Cal's is even lower, children below 250 percent of poverty would be ineligible for these programs only if undocumented. However, children between 250 and 300 percent of poverty are ineligible because of excess family income, so they would not necessarily be undocumented.
8. The information in this section is a summarized synthesis of grantee reports and convening discussions, as well as information gleaned from separately conducted evaluations of the CalKids and FOCUS programs.
9. P. Long, *Local Efforts to Increase Health Insurance Coverage among Children in California* (Oakland: California HealthCare Foundation, Medi-Cal Policy Institute, February 2002).
10. A. Gardner and J. Kahn, *Increasing Access to Care in California Counties: Weighing the Options* (San Francisco: University of California, San Francisco, Institute for Health Policy Studies, 15 August 2002).
11. Proposition 10 raised the state tobacco tax and allocates the increase to fund health programs for children under age six.
12. I. Lay, *State Fiscal Conditions Continue to Deteriorate; Federal Assistance Badly Needed*, 10 October 2002, www.cbpp.org/9-20-02sfp.htm (15 October 2002).