



Realizing the Dream for Californians Eligible for Deferred Action for Childhood Arrivals (DACA): Demographics and Health Coverage

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Realizing the Dream for Californians Eligible for Deferred Action for Childhood Arrivals (DACA): Demographics and Health Coverage

This is the first report in a two-part series on the profile of the DACA-eligible population in California. This report describes health care coverage of DACA-eligible Californians and presents potential policy solutions to expand their coverage options. A [companion report](#) will discuss the health needs, common sources of care, and barriers to care for DACA-eligible Californians and will present potential solutions for health care providers, community-based organizations, and private and public funders to improve health and access to care. Both reports can be found on the UC Berkeley Labor Center [website](#) upon release.

Executive Summary

While millions of Californians are expected to gain health insurance under the Affordable Care Act (ACA), between three and four million Californians are predicted to remain uninsured. Of these, approximately one million are undocumented immigrants who are not eligible for federal coverage options under the ACA. Included in this group are teens and young adults who are eligible for or have been granted Deferred Action for Childhood Arrivals (DACA). California policymakers are currently considering state and local options to expand health coverage to all Californians, including those eligible for DACA. This report describes the demographics and current health coverage of this group.

The DACA program provides temporary work authorization and relief from deportation for undocumented immigrants who arrived in the United States before the age of 16 and were under age 31 as of June 2012. They must currently attend school, have a high school diploma or General Equivalency Diploma (GED), or have an honorable discharge from the U.S. military. An estimated 937,000 individuals nationally were eligible for the DACA program when it began in 2012. This report focuses on the 300,000 or more Californians estimated to be currently eligible. California has more individuals eligible for the DACA program than any other state.

Californians who are now eligible for the program were less likely to have private health insurance either through their own or a family member's job or purchased through the individual market (29 percent) than U.S.-born individuals of the same age (61 percent). These data are from prior to the creation of DACA, and therefore may have improved somewhat due to greater employment opportunities for those granted DACA.

In addition to low levels of private health coverage, DACA-eligible individuals are excluded from coverage through federally-subsidized health programs such as Medicaid or the new insurance options created under the ACA. Furthermore, even if comprehensive immigration reform is enacted, proposals currently under discussion at the national level suggest it is not likely to result in access to affordable health coverage options under the ACA for newly legalized immigrants in the near term.

However, in California, unlike most other states, low-income individuals granted deferred action under DACA are eligible for Medi-Cal under state policy. Most individuals who are eligible for DACA were also

low-income. Of those teens age 18 and under who are eligible for DACA, the vast majority (93 percent) had household income below the Medi-Cal eligibility standard for children (now approximately \$62,900 for a family of four). Nearly two-thirds (62 percent) of DACA-eligible young adults had household income below the Medi-Cal eligibility standard (now approximately \$16,000 for a single individual). In addition, DACA-eligible Californians may be eligible for certain other state, county, and private health programs.

Of the 154,000 Californians granted deferred action under DACA as of December 2013, we estimate that up to 125,000 (81 percent) are eligible for Medi-Cal. This is an upper-limit estimate because individuals granted work authorization under DACA may have been able to secure better employment with increased income and/or access to employment-based health coverage, reducing eligibility and demand for Medi-Cal among this group.

The extent to which these approximately 125,000 Californians enroll in Medi-Cal will depend on how many already have private coverage, the effectiveness of outreach efforts, the ease with which immigrants can enroll, and immigrants' level of confidence that enrolling in Medi-Cal will not result in immigration enforcement actions for them or their family members.

Many DACA-eligible Californians are likely to remain uninsured because they do not qualify for or enroll in Medi-Cal and lack access to affordable private coverage.

This report highlights the gap in coverage for a significant number of young Californians despite the implementation of the ACA. Expanding coverage to teens and young adults granted DACA would reduce the state's uninsured population, increase access to needed care, and reduce the burden on the safety net. Removing barriers to timely preventive and primary care would improve population health and potentially reduce avoidable hospitalizations. These two central aims of the ACA are policy priorities that would be bolstered by healthy DACA-eligible Californians, who are and will continue to be important contributors to the state and its economy.

Key informants interviewed as part of this study made a number of recommendations for short- and long-term solutions to expand health coverage for DACA-eligible Californians. Some of the top priorities include:

- Maintaining and expanding state and county programs for individuals who do not qualify for federal funding due to their immigration status;
- Ensuring that any staff or contractors who provide information to Californians regarding Medi-Cal eligibility (such as Covered California Service Center staff, Certified Enrollment Counselors, or county eligibility workers) are trained on immigrant eligibility for Medi-Cal to ensure a smooth enrollment process for these young immigrants; and
- Passing comprehensive immigration reform that includes a path to citizenship and would allow newly legalized immigrants to immediately access affordable coverage options under the ACA.

Introduction

Limited data is currently available on the demographics and health coverage of the population eligible for the Deferred Action for Childhood Arrivals (DACA) program. The purpose of this study is to fill this information gap and inform providers, stakeholders, and policymakers in developing solutions in California and nationally that would improve access to health care for DACA-eligible teens and young adults. This report is based on research conducted by a team of University of California researchers between May and October 2013 involving analyses of data from the California Health Interview Survey (CHIS) and interviews with key informants. A [companion report](#) presents results from focus groups with DACA-eligible young adults that were also conducted as part of this study.

In addition to describing the characteristics and health care coverage of DACA-eligible Californians, in this report we also present an overview of the health programs available to them and discuss the impact the DACA program has had on coverage. Finally, we present potential policy solutions suggested by key informants that would expand coverage for these young California immigrants.

Summary of Methods

We used data from the 2007 and 2009 California Health Interview Survey (CHIS) to examine the demographic characteristics and health insurance of DACA-eligible individuals in California (for details on methods see Appendix A). Additionally, 28 key informants were interviewed either in person or by phone. Informants included policy experts, advocates, health care providers, DACA-eligible young adults, funders, government officials, and representatives from community-based organizations serving the immigrant community in California (Appendix B). An advisory board of stakeholders in immigration advocacy and health policy guided the design of this study and provided valuable input in the interpretation of results.

Background on Deferred Action for Childhood Arrivals (DACA)

Program Overview

The DACA program was created by an executive order issued by President Obama in 2012 to provide temporary immigration relief for eligible undocumented immigrants who came to the U.S. as children. Individuals approved under the DACA program may be granted work authorization and a reprieve from deportation for two years, subject to renewal. DACA-eligible individuals are immigrants currently without legal documentation who were under the age of 31 as of June 15, 2012, and who arrived in the United States before the age of 16. To be eligible, they must also currently attend school,¹ have a high school diploma or General Equivalency Diploma (GED), or have an honorable discharge from the U.S. military. They also must have resided continuously in the United States since June 15, 2007, and not have any felony convictions, significant misdemeanors, or three or more misdemeanors.² Individuals generally must be at least 15 years old to apply for DACA unless removal or voluntary departure proceedings have occurred or are underway for the applicant.³ Individuals eligible for DACA may also consider themselves DREAMers.⁴

The Immigration Policy Center estimates that nearly 300,000 Californians were eligible for DACA when the program started in 2012, out of nearly 937,000 eligible nationwide. Another 115,000 Californians are expected to become eligible when they reach the age of 15 between 2012 and 2022, assuming the DACA program continues throughout that time period.⁵ Some will only be eligible temporarily if they do not graduate from high school and do not meet any of the other eligibility criteria related to education or military service. Not all individuals eligible for DACA have applied. As of December 2013, more than 174,000 Californians had applied for DACA, representing more than one-quarter of all applications received nationwide; nearly 154,000 California applications have been approved.⁶

DACA and the Affordable Care Act

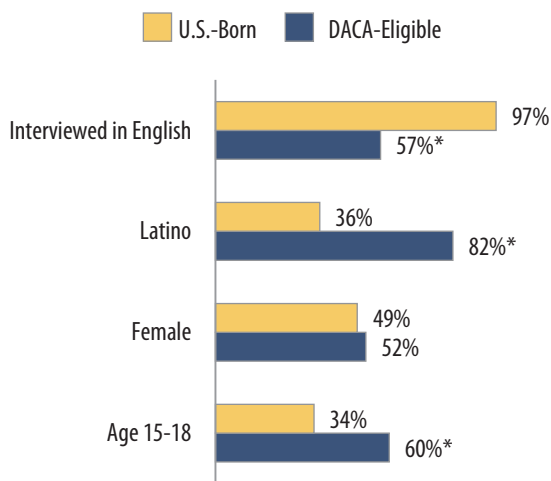
Undocumented immigrants are generally left out of federal health coverage options under the Affordable Care Act (ACA). Out of the predicted total of three to four million Californians expected to remain uninsured under the ACA, approximately one million will be undocumented residents who are ineligible for coverage programs.⁷ Comprehensive immigration reform is currently under discussion in the U.S. Congress. However, based on current bills under consideration, it appears that if immigration reform is enacted it is unlikely to extend eligibility for health coverage options to newly legalized immigrants in the near-term.⁸

Beginning January 1, 2014, the ACA allows citizens and lawfully present immigrants to purchase insurance through new Health Insurance Marketplaces (*Covered California* in California) with federal subsidies for some low- and middle-income enrollees. The ACA also expands eligibility for federal Medicaid coverage (Medi-Cal in California) for citizens and certain lawfully present immi-

grants. The definition of “lawfully present” under the ACA is relatively broad.⁹ However, although the United States Citizenship and Immigration Services (USCIS) considers individuals granted DACA to be lawfully present in the U.S.,¹⁰ the U.S. Department of Health and Human Services (HHS) specifically excluded them from eligibility for health insurance through federal Medicaid and the Marketplaces, with or without subsidies.¹¹ As a result of being excluded from the HHS definition of “lawfully present,” they are explicitly exempt from the ACA’s requirement to have insurance.¹²

Medi-Cal provides affordable coverage to low-income children, parents, seniors, and persons with disabilities, and takes advantage of all federal funding available to expand coverage to as many Californians as possible. California goes one step further by using state funds to provide full-scope Medi-Cal to certain immigrants who are otherwise eligible, including individuals granted DACA.

Exhibit 1: Demographics of DACA-Eligible and U.S.-Born Californians Ages 15–30, 2009–07



Source: California Health Interview Survey, combined 2009 and 2007 data
*Significantly different from the U.S.-born population ($p < 0.05$)

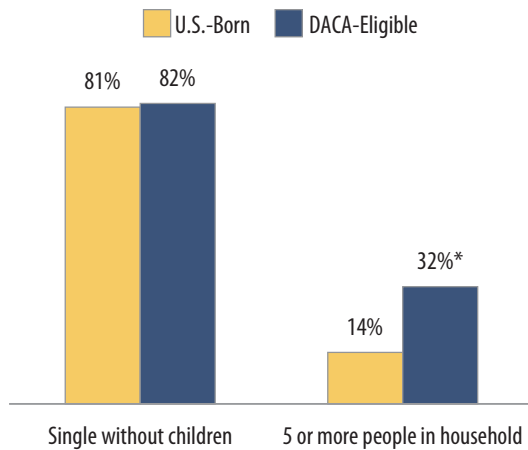
Demographics and Insurance Coverage of DACA-Eligible Californians

In this section, the demographics and insurance coverage of DACA-eligible individuals living in California are compared to those of U.S.-born individuals ages 15 to 30 living in California. Comparisons among all immigration categories, including naturalized citizens, lawful permanent residents, those with temporary legal status, and other undocumented individuals unlikely to be eligible for DACA, are provided in Appendix C.

Ethnicity, Language, Gender, Age, and Family Status

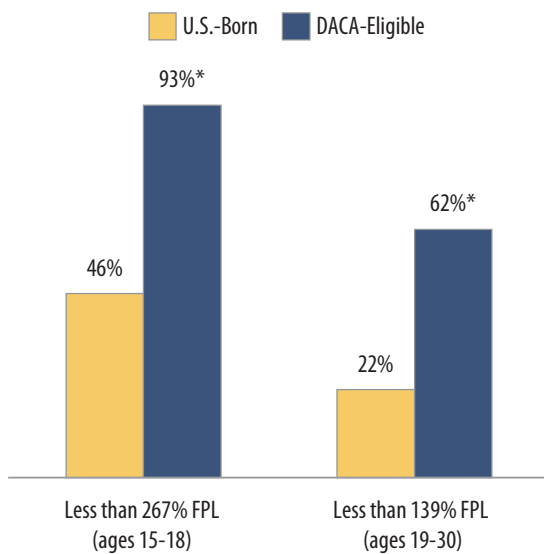
The majority of DACA-eligible Californians were Latino (82 percent) and at least 57 percent were considered fluent in spoken English because they elected to be interviewed in English for the CHIS (Exhibit 1). These individuals were also about as likely to be female (52 percent) as the U.S.-born population (49 percent) in the same age category. Most (60 percent) DACA-eligible Californians

Exhibit 2: Family Status among DACA-Eligible and U.S.-Born Californians Ages 15–30, 2009–07



Source: California Health Interview Survey, combined 2009 and 2007 data
*Significantly different from the U.S.-born population ($p < 0.05$)

Exhibit 3: Percent of DACA-Eligible and U.S.-Born Californians Ages 15–30 with Incomes Below the Federal Poverty Level (FPL) Thresholds for Medi-Cal, 2009–07



Source: California Health Interview Survey, combined 2009 and 2007 data
Note: Under state policy, the Medi-Cal income eligibility threshold for children under age 19 is below 267 percent FPL, or approximately \$62,900 for a family of four. The threshold for adults is below 139 percent FPL, or approximately \$16,000 for a single individual.

*Significantly different from the U.S.-born population ($p < 0.05$)

were teens between the ages of 15 and 18. We assumed all respondents 18 years of age and under were currently enrolled in school, which is likely to overestimate the number of DACA-eligible teens because some may have dropped out of high school without receiving a GED. Due to limited data, our methods also may underestimate the share over 18 who are currently in school; see Appendix A for more information.

The DACA-eligible Californians were as likely to be single without children (82 percent) as U.S.-born citizens (81 percent; Exhibit 2). Nearly one-third (32 percent) of DACA-eligible Californians lived in households of five or more members, significantly greater than the 14 percent of U.S.-born citizens. These DACA-eligible households are likely to include both young adults and children who immigrated to the U.S. with their parents in search of education and jobs for their families.

Fewer DACA-eligible individuals (36 percent) reported always feeling safe in their neighborhoods, compared to 56 percent of U.S.-born individuals (Appendix C). Information on the reasons for not feeling safe is not available in the survey.

Income and Employment Status

DACA-eligible individuals were more likely than U.S. citizens to be low-income. More than nine out of ten (93 percent; Exhibit 3) DACA-eligible California teens between the ages of 15 and 18 lived in families with incomes below 267 percent of the Federal Poverty Level (FPL), the threshold for Medi-Cal eligibility for children 18 years and younger under state policy, in 2007 or 2009. In contrast, 46 percent of U.S.-born teens were in the same income category. Nearly two-thirds (62 percent) of DACA-eligible young adults between the ages of 19 and 30 had incomes below 139 percent FPL, the threshold for Medi-Cal eligibility for parents and childless adults. Significantly fewer U.S.-born young adults (22 percent) were in this income category. Overall, up to 81 percent of DACA-eligible teens and young adults, or up to

125,000 of the 154,000 Californians granted DACA, are estimated to be eligible for Medi-Cal based on their households' incomes in 2007 or 2009.

The rate of employment of DACA-eligible young adults was significantly lower than U.S.-born young adults in the 2007-2009 time period (56 percent and 74 percent, respectively; Appendix C). Other analysis indicates greater labor-market participation of the overall undocumented population than U.S.-born individuals and greater likelihood of looking for work among unemployed undocumented immigrants compared to unemployed U.S.-born individuals.¹³ The lower rate of employment among DACA-eligible young adults using the CHIS data is likely due to the higher impact of the recent recession in California in industries where these young adults were employed.

These income and employment estimates are based on the CHIS conducted in 2007 and 2009, prior to the creation of the DACA program. The employment rate of DACA-eligible Californians may have increased since the survey was conducted as a significant share of these individuals has been granted work authorization. A national survey of individuals granted DACA found that 61 percent obtained a new job since being granted DACA, demonstrating the impact the program has had on employment opportunities.¹⁴ Expanded employment opportunities could also result in potential increases in income for individuals granted DACA, especially young adults.

If the income and employment rates of young adults granted DACA begin to look more like the income and employment rates of other authorized immigrants of the same age (19-30) we would expect a lower share (40 percent) of DACA-eligible young adults to be eligible for Medi-Cal based on household income and a higher share to be employed (Appendix C).

Insurance Coverage

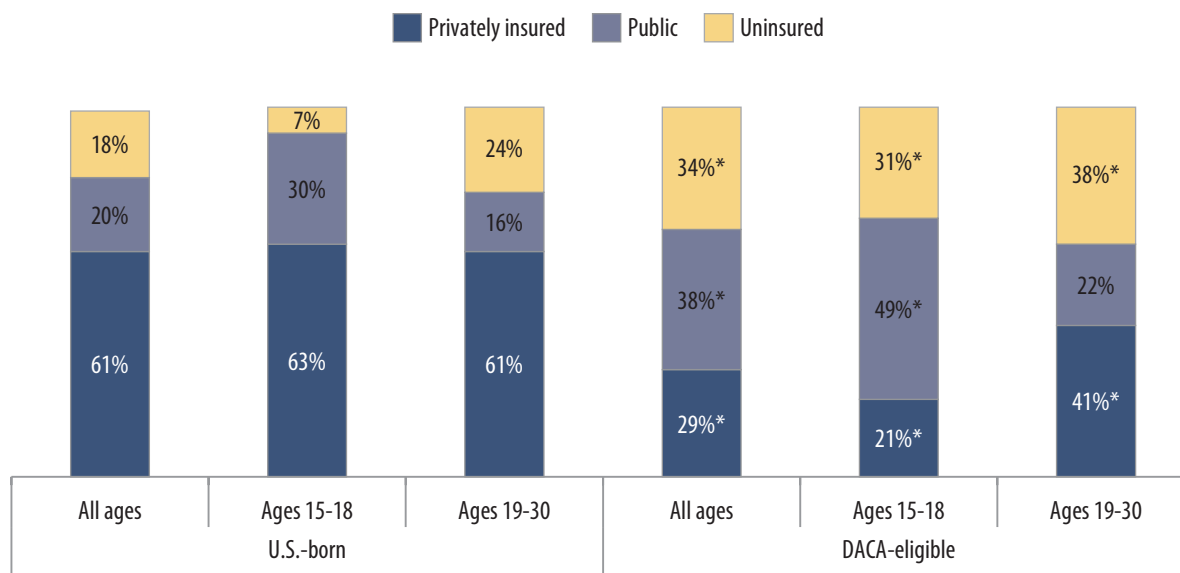
DACA-eligible uninsured teens and young adults comprise 3 percent of the total uninsured population ages 15-30 examined in this study (data not shown). However, DACA-eligible teens and young adults were more often uninsured (34 percent) than U.S.-born individuals ages 15-30 (18 percent; Exhibit 4, page 10). Given differences in age-specific coverage programs for the DACA-eligible population, current insurance coverage is also presented by age category. Nearly one-third (31 percent) of DACA-eligible teens ages 15-18 reported no insurance coverage, significantly more than the seven percent of U.S.-born teens of the same age who were uninsured.

DACA-eligible teens were also less likely (21 percent) to have private insurance coverage through their own job, a family member's job, or the individual market, compared to their U.S.-born counterparts (63 percent). DACA-eligible young adults were also less likely to have private insurance coverage (41 percent) than U.S.-born young adults (61 percent). In total, 29 percent of DACA-eligible Californians had private coverage compared to 61 percent of U.S.-born individuals of the same age.

Rates of private insurance coverage for individuals granted DACA may have increased since the survey was conducted in 2007 and 2009 as individuals gained work authorization, which may result in greater access to employment-based health coverage.

The remainder of the DACA-eligible population reported having received some form of public coverage. The likely sources of this coverage are programs that are available to all Californians regardless of immigration status, including Healthy Kids and restricted-scope Medi-Cal which covers limited benefits such as emergency and pregnancy-related services. These programs are described in the next section of this report, "Current Health Program Eligibility for DACA-Eligible Californians," and in Appendix E.

Exhibit 4: Self-Reported Insurance Coverage of DACA-Eligible and U.S.-Born Californians Ages 15–30, 2009–07



Source: California Health Interview Survey, combined 2009 and 2007 data

Note: Privately insured includes job-based coverage and insurance purchased through the individual market. Public sources of coverage reported by DACA-eligible and U.S.-born individuals differ. Public coverage for DACA-eligible populations is frequently restricted-scope coverage, but also includes Healthy Kids for teens. U.S.-born public coverage is primarily full-scope Medi-Cal and Healthy Families, in addition to the temporary and restricted-scope coverage for specific conditions.

*Significantly different from the U.S.-born population ($p < 0.05$)

Current Health Program Eligibility for DACA-Eligible Californians

California is relatively unique in that some of its state, county, and privately-funded health programs are available to residents, regardless of immigration status, including DACA-eligible individuals. This section summarizes some of these programs.

Low-Income Individuals Granted DACA are Eligible for Medi-Cal

Similar to other low-income, lawfully present immigrants, Californians granted DACA fall under the state's definition of Permanently Residing in the U.S. under Color of Law (PRUCOL) and are eligible for state-funded full-scope Medi-Cal benefits.¹⁵ This eligibility includes children in

households with income below 267 percent of the Federal Poverty Level (FPL), parents and childless adults who have household incomes below 139 percent FPL, persons with disabilities, and individuals age 65 and older.¹⁶ (See Appendix D for annual income levels as a percentage of FPL for the thresholds listed in this section.)

Beginning January 1, 2014, Medi-Cal participating hospitals are now able to preliminarily enroll patients who may be eligible for Medi-Cal based on their income and provide temporary Medi-Cal benefits for 60 days ("presumptive eligibility") while a full eligibility determination is completed. Prior to 2014, this enrollment option was limited to certain providers and to patients who were under the age of 19, pregnant, or diagnosed with breast or cervical cancer. The ACA and state law expanded this enrollment option to all participating

hospitals whose patients appear to be eligible for Medi-Cal based on their income, including parents and childless adults.¹⁷ This enrollment option will improve access to Medi-Cal by allowing eligible uninsured individuals, including individuals granted DACA, who are at the hospital for medical services to be temporarily enrolled into Medi-Cal while their application is reviewed.

In October 2013, U.S. Immigration and Customs Enforcement (ICE) reconfirmed its long-standing policy that it will not use information about applicants or family members that is obtained for purposes of determining eligibility for Medicaid or Marketplace coverage as the basis for pursuing a civil immigration enforcement action against applicants or their family members.¹⁸ This announcement may help increase Medi-Cal and Covered California enrollment because it may help decrease the fear among eligible individuals of putting themselves or their undocumented family members at risk of deportation or other immigration enforcement.

California has other health programs that are open to DACA-eligible Californians and all income-eligible residents regardless of immigration status. For example, all pregnant women with household income below 214 percent FPL, regardless of immigration status, are eligible for pregnancy-related Medi-Cal benefits. In addition, low-income residents are eligible for restricted scope Medi-Cal which covers emergency services, regardless of immigration status. These programs and others which provide limited health services or are available only to individuals who meet other program eligibility requirements are listed in Appendix E.

Other Programs are Available to DACA-Eligible Californians in Some Counties

Uninsured DACA-eligible individuals, like other uninsured Californians, are also eligible to enroll in indigent care programs for uninsured low-income residents in certain counties, but income and immigration eligibility standards vary. Programs such as Healthy Way L.A. “Unmatched”

(meaning without federal matching funds), Healthy San Francisco, and Alameda County HealthPAC are available regardless of immigration status. Services provided to undocumented residents through these programs are locally funded, using county indigent care funds and other local funds. The services offered vary by county, but the programs in Los Angeles, San Francisco, and Alameda Counties all offer primary care, emergency care, mental health services, and prescription drugs. In addition, these programs offer enrollees a medical home that helps to facilitate and encourage utilization of primary and preventive care, rather than episodic care.¹⁹ Additionally, in Los Angeles County the Outpatient Reduced-Cost Simplified Application (ORSA) covers outpatient medical care and prescription drugs at county-run health facilities and the Ability-To-Pay (ATP) program covers prenatal and maternity care, prescription drugs, and hospitalization at county-run health facilities.²⁰ Some counties are considering changes to program benefits, cost-sharing, or eligibility in response to the ACA and the end of the Low Income Health Program under California’s Bridge to Reform Demonstration.²¹

The Healthy Kids programs, operating in approximately 13 California counties (11 of which are accepting new enrollments), are funded through a combination of public and private sources. Healthy Kids is an insurance program that provides comprehensive medical, dental, and vision coverage and is open to uninsured county residents up to age 19 (but limited to under age 6 in certain counties) who are living in families with income under 300 percent FPL and who are not eligible for full-scope Medi-Cal, regardless of immigration status. Approximately 26,000 Californians are currently enrolled, down from a peak of more than 86,000 in 2006.²² Reductions in funding have caused enrollment to decline and some counties have long wait lists.

The Kaiser Permanente (KP) Child Health Program is a Community Benefit (CB) program that provides a KP premium subsidy for uninsured California children regardless of immigration status.

The program is for Californians under the age of 19 who are not eligible for Medi-Cal, do not have access to employer-sponsored dependent coverage, and are living in families with income under 300 percent FPL. The program includes medical, dental, vision, and mental health coverage, and costs \$0, \$10 or \$20 per child per month. After three children are enrolled, there is no monthly premium for each additional child. There are also no co-pays for services at KP facilities. Dental coverage is provided through Delta Dental. Approximately 80,000 California children are enrolled in the program. The program is available for children living in a Kaiser Permanente Service Area, which includes 30 counties across the state. Enrollment is often closed in Southern California due to demand and enrollment limits.²³

This uneven quilt of state, county, and private health programs can fill gaps for some DACA-eligible individuals in the state, depending on age, county of residence, income level, their knowledge of such options, and other factors. However, diverse eligibility requirements, concerns about deportation if services are used, and funding limits contribute to a fragmented portfolio of available options and leave many without a regular source for affordable care.

The Impact of the DACA Program on Health Coverage

Since the DACA program was created, individuals granted work authorization may have gained better access to job-based health insurance as a result of expanded employment opportunities.

The DACA program also expands access to coverage in California by enabling low-income teens and young adults to enroll in Medi-Cal. Of the 154,000 Californians who had been granted deferred action under DACA as of December 2013, we estimate that up to 125,000 (81 percent) would have been eligible for Medi-Cal based on their households' incomes in 2007 or 2009, according

to analyses of CHIS data described earlier in this report. This is an upper-limit estimate for 2013. Improved employment opportunities may have increased income, reducing eligibility for Medi-Cal. Some of the individuals in this estimate are also likely to have gained private coverage as a result of the expanded employment opportunities that result from work authorization under DACA.

Approximately 115,000 Californians are estimated to become newly eligible for DACA upon reaching the age of 15 through the year 2022, assuming the program is maintained.²⁴ However, it is difficult to predict the number of Californians who will be granted and maintain DACA in future years, and therefore will be potentially eligible for Medi-Cal if low-income. The number will depend on:

- Federal action to continue the DACA program;
- The share of those eligible who apply for the DACA program;
- The share of those granted DACA who renew their applications every two years; and
- The share of individuals who lose eligibility for the DACA program because they drop out of high school and do not meet the other education or military criteria.

While some Californians will be eligible for Medi-Cal as a result of DACA, many are likely to remain uninsured, especially those over the age of 18.

Some DACA-eligible Californians are likely to remain uninsured because they are ineligible for affordable coverage due to living in a household with income that exceeds the eligibility threshold. Many of these individuals would otherwise be eligible to buy subsidized coverage through the Marketplaces based on income, but because of their exclusion from the ACA they are ineligible just like undocumented immigrants.

The health coverage options of undocumented teens and young adults who have not received

DACA remain limited. Approximately half of Californians eligible for the DACA program have applied and received approval.²⁵ While the share of young California immigrants granted DACA continues to grow, the cost of applying for DACA (currently \$465 per application), lack of awareness about the program, and fear of triggering immigration enforcement for undocumented family members or themselves may continue to prevent some eligible individuals from applying for and gaining deferred action under DACA.²⁶ Individuals granted DACA must renew their applications every two years, which could also affect the share of eligible Californians granted DACA.

Finally, many Californians who are eligible for health coverage, whether citizens, lawful permanent residents, or DACA-eligible, are likely to remain unenrolled due to lack of awareness about their eligibility for coverage programs, challenges in the enrollment process, or inability to afford private coverage.²⁷ Key informants identified barriers to coverage that may particularly affect DACA-eligible Californians:

- A lack of knowledge of the programs for which they are eligible;
- Misinformation or unclear information regarding coverage options, including that provided by individuals or organizations that assist with enrollment;
- Inexperience with health insurance due to being uninsured as children and parents' lack of coverage;
- Burdensome paperwork requirements; and
- Fear that enrollment may place them or any undocumented family members at risk of deportation or concerns about whether enrolling in public programs may jeopardize future citizenship.

Targeted outreach, a simplified enrollment process, and trust of government agencies will affect the extent to which eligible individuals enroll.

Potential Policy Solutions for Expanding Coverage for DACA-Eligible Californians

More than two dozen key informants were asked to identify potential solutions that would improve health for DACA-eligible Californians. They recommended a wide range of solutions related to expanding coverage that would potentially benefit DACA-eligible Californians, other undocumented residents, and uninsured Californians more generally.

Expand Coverage Eligibility through Immigration Reform

Some key informants described immigration reform as an important potential path to ACA coverage eligibility. They recommended that comprehensive immigration reform not only establish a path to citizenship, but also allow newly legalized immigrants immediate access to affordable coverage through the Marketplaces and federal Medicaid. They also noted that it is important that immigration reform not prohibit individuals from securing coverage as a condition of gaining lawful status.

Expand Eligibility for Affordable Care Act Programs

Many key informants supported expanding access to health coverage regardless of immigration status. At a minimum, some recommended that the federal Department of Health and Human Services reverse its decision to exclude individuals granted DACA from the federal definition of eligible "lawfully present" immigrants under the ACA. In addition to expanding Medicaid eligibility nationally, this would allow individuals with DACA, like other lawfully present immigrants, to gain access to coverage through the Health Insurance Marketplaces and receive premium tax credits and cost sharing subsidies if they are income eligible. Some key informants emphasized that expanding Marketplace plan eligibility to individuals with DACA, all of whom are (at this time) relatively young and therefore more likely to be healthy, would likely

help create a more balanced risk pool in the Marketplaces, which could help ensure that premiums are as affordable as possible for all enrollees.

Maintain and Expand State and County Coverage Programs

Key informants noted the importance of maintaining long-standing state or local programs that are currently open to a broad group of immigrants, including residents of California who have been granted DACA, or are available regardless of immigration status. Key informants also suggested that it is important to encourage hospitals to provide presumptive eligibility for potential Medi-Cal eligible patients.

Some key informants suggested that state policymakers could reduce the number of undocumented Californians remaining uninsured by creating a parallel, or “mirror,” Marketplace for Californians who are not eligible for Covered California due to their immigration status. Under this proposal, the infrastructure of the parallel Marketplace would mimic Covered California to the extent allowed under federal law, including potentially sharing the same front portal, offering plans similar to those offered through Covered California, and providing information that would help consumers to choose between plans. The state could also consider funding premium and/or cost sharing subsidies based on income.

Key informants also recommended that counties currently offering care to low-income uninsured residents regardless of immigration status (such as Healthy Way L.A., Healthy San Francisco, and Alameda County HealthPAC) maintain these programs, and that counties and the state adequately fund these programs. Others suggested that counties that do not have programs for the remaining uninsured should consider establishing them because citizens as well as immigrants in California are likely to remain uninsured. An important component of these programs is that they offer a

medical home to enrollees, encouraging the use of cost-effective primary and preventive care and helping enrollees to navigate the health care system. Encouraging counties with strong programs to share best practices would promote the establishment of new programs. Key informants also recommended continued support and increased funding for county-based Healthy Kids programs.

Finally, legislators have proposed expanding access to coverage for some or all low-income California residents, regardless of their immigration status.²⁸ This would include expanding state-funded Medi-Cal and establishing a parallel or mirror Marketplace for those individuals not eligible for coverage under the ACA.

Ease Enrollment Process for State and County Health Programs

Key informants made recommendations to ensure that California immigrants who are eligible for public coverage receive accurate and easy to understand information about their eligibility and are able to enroll in coverage with ease at any application entry point. Covered California, the state Department of Health Care Services, and county agencies responsible for eligibility determinations should include clear, language appropriate, and accurate information regarding Medi-Cal eligibility for California immigrants—on their websites, in written materials for the public including the streamlined application, and on telephone hotlines. Robust training on Medi-Cal eligibility for immigrants should be provided to Covered California Service Center staff, Certified Enrollment Counselors, county eligibility workers, and any other staff or contractors who provide information to Californians regarding Medi-Cal eligibility.²⁹ Where relevant, publicly-available information and trainings should also include eligibility information about county programs for which immigrants are eligible.

Expand Job-Based Coverage

In addition to expanding public coverage programs, expanding job-based coverage is another means of improving access to health care for DACA-eligible Californians. Federal, state, and local policies that require or provide incentives for employers to help employees pay for and access health services would benefit DACA-eligible Californians, many of whom are employed but uninsured. For example, the San Francisco Health Care Security Ordinance requires businesses with at least 20 employees to make expenditures towards their employees' health care.

Industry-specific solutions should also be considered. The Restaurant Opportunities Center's ROC M.D. program enables uninsured restaurant workers in Los Angeles to access primary and preventive care services at St. John's Well Child and Family Center, and also covers low-cost prescriptions, labs and x-rays, and two dental visits per year. The program is generally funded through grants and a low monthly fee (\$25) paid by members, but restaurant employers can also pay into the program for their employees. While not insurance, the program helps ensure that workers get the preventive and primary care they need, as well as have a medical home.³⁰

Summary and Conclusions

The implementation of the Affordable Care Act is projected to significantly reduce the number of uninsured by expanding Medicaid, establishing Marketplaces, and providing federal subsidies for coverage for many individuals based on income. This report highlights the gap in coverage for a significant number of young Californians despite the implementation of the ACA. Individuals granted DACA have been specifically excluded from these federal programs. Potential passage of comprehensive immigration reform or the DREAM Act may grant some young immigrants a path to citizenship, but current proposals would not remove

existing barriers in access to federally-funded health insurance and care.

In California, some individuals granted DACA are eligible for state-funded Medi-Cal, along with other state, county, and private health programs. Key informants recommended that these programs be maintained and, in some cases, expanded. Additionally, Covered California Service Center staff, Certified Enrollment Counselors, and county eligibility workers should be trained on immigrant eligibility for Medi-Cal and Covered California to ensure a smooth enrollment process for Californians granted DACA.

Some DACA-eligible individuals are likely to remain uninsured because they are not eligible for coverage options, are unaware of their eligibility, encounter difficulties enrolling, cannot afford private coverage, and/or are concerned about whether enrolling in programs may place them or other family members at risk of deportation or jeopardize future citizenship. They may also view health coverage as a luxury over the family's basic necessities such as food and shelter.

Despite these challenges and obstacles, the number of Californians who remain uninsured can be minimized through the passage and implementation of policies recommended by immigration and health policy advocates. Expanding coverage to teens and young adults granted DACA would reduce the state's uninsured population, increase access to needed care, and reduce the burden on the safety net. Removing barriers to timely preventive and primary care would improve population health and potentially reduce avoidable hospitalizations. These two central aims of the ACA are policy priorities that would be bolstered by healthy DACA-eligible Californians, who are and will continue to be important contributors to the state and its economy.

Appendix A: Methods

The research procedures were approved by the Institutional Review Board of the University of California, San Francisco.

California Health Interview Survey (CHIS)

We used data from the 2011-12, 2009, and 2007 California Health Interview Surveys (CHIS). We obtained the estimates of the undocumented population and those eligible for DACA from the latest available CHIS cycles (2011-12). However, we used the combined 2009 and 2007 surveys to examine the demographic characteristics and health insurance of DACA-eligible individuals in California due to the limited sample size of the 2011-12 data.

CHIS is a landline and cell phone survey of the state's non-institutionalized population and is representative of multiple racial/ethnic populations in California. CHIS is conducted in six languages to include populations with limited or no English proficiency. This data source is especially well-suited to identify and analyze characteristics of the undocumented and DACA populations because it contains multiple questions on nativity and immigration status.

The overall population was divided into four immigration status categories—U.S.-born, naturalized citizens, lawful permanent residents/temporary legal status, and undocumented. The undocumented population in California was estimated using statistical modeling techniques among individuals without a green card or those who reported being naturalized, but who had not lived in the U.S. long enough to be citizens under most circumstances.

The population eligible for DACA was identified from within the undocumented population based on the current criteria for DACA, including: 1) arrival in the U.S. prior to 16 years of age; 2) at least a high school diploma or equivalency for respondents ages 19-30; and 3) assuming all respondents 18 years of age and under were currently enrolled

in school. Information on other criteria for DACA eligibility could not be identified in CHIS, including: 1) current enrollment in a program working toward placement in post-secondary education, job training, or employment; 2) honorable discharge from the U.S. military; 3) lack of a criminal record; and 4) continuous physical presence in the U.S. since June 2007.

The method of identifying DACA-eligible individuals is likely to overestimate the number of teens 18 years of age or younger because some may have dropped out of high school without receiving a GED. These methods may also overestimate eligibility for those who had criminal records, or were not continuously present in the U.S. Our methods are likely to underestimate eligibility among individuals 19-30 year-olds who may be actively pursuing a post-secondary or vocational degree. Of these limitations, underestimation of those pursuing further education and overestimation of individuals who had dropped out of high school to work may have the largest impact on our estimates. Significance tests were conducted to compare differences across immigration categories in the population ages 15-30.

An estimated 2.2 million undocumented immigrants are living in California, according to CHIS data from 2011-12. An estimated nine percent, or 188,000 individuals, are between the ages of 15 and 30, have lived in the U.S. since the age of 15 or younger, and are currently enrolled in a high school program or have a high school diploma or equivalent certification. These individuals are potentially eligible for DACA, assuming that they meet all of the program requirements.

The CHIS-estimated number of potential DACA-eligible individuals in California is lower than in other studies. For example, the Immigration Policy Center estimates that 298,000 Californians were eligible for DACA in 2012.³¹ The lower CHIS estimate is due to the limitations of survey data in assessing eligibility status.³² For example, CHIS does not capture student status of individuals 19-30 years of

age who are pursuing a post-secondary or vocational degree. Another reason for underestimation of the DACA-eligible population may be lower response rates of young populations in statewide surveys such as CHIS. Despite such limitations, CHIS is the premier source of population-based health information in California and these data are the most representative data available on the profile of the undocumented population in general and the DACA-eligible population specifically.

Key Informants

Twenty-eight key informants were interviewed either in person or by phone. Informants included policy experts, advocates, health care providers, DACA-eligible young adults, funders, government officials, and representatives from community-based organizations serving the immigrant community in California (Appendix B). Interviews lasted approximately 30 to 90 minutes and involved questions intended to validate and contextualize quantitative and focus group results, understand key concerns, describe existing resources and programs, and identify potential solutions for improving health and health care access for DACA-eligible young adults in California.

Following completion of these methods, the research team shared preliminary results with the study's advisory board and other key stakeholders who supported the validity of the study's findings and overall consistency with their experiences working with the DACA-eligible community. Thus, these sources of information, combined with the companion focus group results, provide a nuanced and in-depth profile of DACA-eligible Californians.

Appendix B: Key Informants Interviewed

The following individuals participated in key informant interviews:

- Harrison Alter, MD, MS, FACEP, Research Director, Department of Emergency Medicine, Alameda Health System—Highland Hospital
- Sonal Ambegaokar, JD, Senior Attorney, National Health Law Program (formerly with National Immigration Law Center)
- Isabel Becerra, Chief Executive Officer, Coalition of Orange County Community Health Centers
- Mario Chavez, Director of Community Relations, St. John’s Well Child & Family Center
- Marlon Cuellar, Program Manager, The California Endowment
- Crispin Delgado, MPP, Program Officer, Health Care and Coverage, Blue Shield of California Foundation
- Mark Ghaly, MD, MPH, Deputy Director for Community Health, Los Angeles County Department of Health Services
- David Hayes-Bautista, PhD, Professor of Medicine and Director, Center for the Study of Latino Health and Culture at the School of Medicine, University of California, Los Angeles
- Kanthalak Latthivongskorn, Intern, DREAM Summer
- Jirayut New Latthivongskorn, Co-Founder, Pre-Health Dreamers
- Laura López, Executive Director, Street Level Health Project
- Arlette Lozano, Intern, DREAM Summer
- Louise McCarthy, MPP, President and Chief Executive Officer, Community Clinic Association of LA County
- Gary Mendoza, JD, Founder and Chief Executive Officer, iPaseo Health Partners
- Hector Alessandro Negrete, Statewide Coordinator, California Immigrant Youth Justice Alliance
- Luis Pardo, Executive Director, Worksite Wellness LA
- Nora E. Phillips, Staff Attorney (admitted in Illinois), formerly with CARECEN
- Imelda S. Plascencia, Project Coordinator of Health Initiatives, Dream Resource Center, UCLA Labor Center
- Natalia Rodriguez, Workplace Justice Organizer, Restaurant Opportunities Center of Los Angeles
- Seth Hernandez Ronquillo, Co-Chair, IDEAS at UCLA
- Vanessa R. Saavedra, JD, Assistant Director of Legal Affairs and Policy, California Primary Care Association
- Cary Sanders, MPP, Director of Policy Analysis and the Having Our Say Coalition, California Pan-Ethnic Health Network
- Reshma Shamasunder, Executive Director, California Immigrant Policy Center
- Suzie Shupe, JD, Executive Director, and Anna Hasselblad, Communications and Operations Manager, California Coverage & Health Initiatives
- Meng L. So, MA, Director, Undocumented Student Program, UC Berkeley
- Celinda M. Vázquez, Vice President of Public Affairs, Planned Parenthood Los Angeles
- Anthony Wright, Executive Director, Health Access California
- Lucien Wulsin, JD, Executive Director, Insure the Uninsured Project

Appendix C: Demographics and Insurance Coverage by Immigration and Citizenship Status, Californians, Ages 15–30, 2009–07

	U.S.-Born	Confidence Interval	Naturalized Citizens	Confidence Interval	Authorized Immigrants	Confidence Interval	DACA-Eligible	Confidence Interval	Other Unauthorized	Confidence Interval	P-value**
Demographics											
Total	6,562,000		618,000		523,000		188,000		610,000		
Ages 15-18	34%	32-35%	14%	11-17%	19%	16-23%	60%	51-69%	2%*	0.8-3%	<.0001
Female	49%	47-51%	45%	39-51%	52%	47-57%	52%	42-61%	49%	43-56%	0.6335
Latino	36%	35-39%	41%	34-48%	58%	52-63%	82%	74-88%	81%	74-86%	<.0001
Interviewed in English	97%	97-98%	90%	87-92%	61%	56-66%	57%	48-66%	22%	17-29%	<.0001
Single without children	81%	80-82%	71%	64-77%	60%	54-64%	82%	73-89%	42%	35-48%	<.0001
5 or more people in household	14%	13-15%	13%	7-21%	14%	11-17%	32%	24-41%	14%	10-18%	<.0001
Always feels safe in neighborhood	56%	54-58%	45%	38-52%	51%	45-57%	36%	25-48%	54%	48-60%	<.0001
Employed (Age 19-30)	74%	72-76%	67%	58-74%	73%	66-78%	56%	39-71%	57%	50-64%	<.0001
Income (% FPL)											
Ages 15-18	2,209,000		84,000		100,000		113,000		10,000		
Less than 267%	46%	43-48%	59%	48-69%	74%	65-81%	93%	87-96%	89%	66-97%	<.0001
Ages 19-30	4,353,000		534,000		423,000		75,000		600,000		
Less than 139%	22%	20-23%	30%	23-38%	40%	34-46%	62%	47-75%	68%	61-75%	<.0001
Health insurance***											
All ages											<.0001
Uninsured	18%	17-20%	20%	16-26%	35%	30-41%	34%	26-42%	47%	41-54%	
Private	61%	60-63%	60%	54-66%	43%	38-49%	29%	20-39%	24%	19-30%	
Public	20%	19-22%	19%	13-27%	21%	18-26%	38%	30-47%	29%	23-36%	
Ages 15-18											<.0001
Uninsured	7%	6-9%	9%*	5-16%	25%	17-35%	31%	22-42%	58%	26-85%	
Private	63%	60-65%	59%	48-68%	30%	22-38%	21%	12-33%	38%*	13-72%	
Public	30%	27-33%	32%	23-43%	46%	36-56%	49%	38-59%	4%*	1-16%	
Ages 19-30											<.0001
Uninsured	24%	22-26%	22%	18-28%	38%	32-44%	38%	25-52%	47%	41-53%	
Private	61%	59-63%	60%	53-68%	47%	40-53%	41%	25-58%	24%	19-29%	
Public	16%	14-17%	17%	11-27%	16%	12-20%	22%	11-37%	29%	23-36%	

Source: California Health Interview Survey, combined 2009 and 2007 data

*Estimate is unreliable

**P-values indicate overall differences in rates by immigration status

*** Private insurance includes job-based coverage and insurance purchased through the individual market. Public sources of coverage reported by DACA-eligible and U.S.-born individuals differ. Public coverage for DACA-eligible populations is frequently restricted-scope coverage, but also includes Healthy Kids for teens. U.S.-born public coverage is primarily full-scope Medi-Cal and Healthy Families, in addition to the temporary and restricted-scope coverage for specific conditions.

Appendix D: Annual Income as a Percentage of Federal Poverty Level

Family Size	Federal Poverty Level					
	139%	201%	214%	267%	300%	322%
1	\$15,971	\$23,095	\$24,589	\$30,678	\$34,470	\$36,998
2	\$21,559	\$31,175	\$33,191	\$41,412	\$46,530	\$49,942
3	\$27,147	\$39,255	\$41,794	\$52,145	\$58,590	\$62,887
4	\$32,735	\$47,336	\$50,397	\$62,879	\$70,650	\$75,831
5	\$38,322	\$55,416	\$59,000	\$73,612	\$82,710	\$88,775

Source: U.S. Department of Health and Human Services, Federal Poverty Guidelines, 2013

Appendix E: Statewide Public Programs for DACA-Eligible Californians

Program	Eligibility	Services
Full Scope Medi-Cal	Individuals granted deferred action under DACA with household income below 139% FPL for childless adults and parents or below 267% FPL for children; individuals with disabilities also eligible	Full-scope Medi-Cal benefits
Emergency/ Restricted Scope Medi-Cal	Otherwise eligible for Medi-Cal*	Medically needed care in order to prevent death, or impairment of the body or the body's functions, including dialysis and emergency room care
Pregnancy-Only Medi-Cal	Pregnant women with incomes below 214% FPL*	Pregnancy-related care
Access to Infants and Mothers (AIM) program	Pregnant women with incomes between 214- 322% FPL*	Low-cost health coverage which covers all medically necessary services until the 60th day after a pregnancy has ended ³³
Long-Term Care³⁴	Otherwise eligible for Medi-Cal*	Long-term care such as nursing home services
Breast and Cervical Cancer Treatment Program	Women with breast or cervical cancer who do not have a disability*	18 months of treatment for breast cancer and 24 months for cervical cancer
Every Woman Counts	Women age 40 and older (breast cancer screenings) and age 25 and older (cervical cancer screenings) with income below 201% FPL*	Annual screenings and diagnostic services for breast and cervical cancer
FamilyPACT	Income below 201% FPL*	Comprehensive family planning services and supplies
Medi-Cal Minor Consent Services	Children under age 21, does not require parental consent or notification*	Services such as substance abuse treatment, mental health services, family planning services, and STD diagnosis and treatment
Child Health and Disability Prevention (CHDP) Program and CHDP Gateway	Children under age 19 who are not eligible for Medi-Cal with family income below 201% FPL, or under age 21 with Medi-Cal under the Federal Early and Periodic Screening, Diagnostic and Treatment Program*	Periodic preventive health assessments, including medical, vision and hearing screenings, and immunizations; referrals for diagnosis and treatment when necessary; up to two months of full-scope Medi-Cal
California Children's Services	Children under age 21 with certain diseases or health conditions*	Diagnostic and treatment services, medical case management, and physical/ occupational therapy services ³⁵
Victim Compensation Program³⁶	Crime victims*	Crime-related medical, dental, and mental health care

* Eligible regardless of immigration status

Sources (unless otherwise noted): National Immigration Law Center.³⁷ The California Endowment.³⁸ Health Initiatives of the Americas, UC Berkeley School of Public Health.³⁹

Endnotes

- 1 This includes those enrolled in a public or private school for kindergarten through high school; individuals enrolled in “an education, literacy, or career training program (including vocational training) that is designed to lead to placement in postsecondary education, job training, or employment and where [the individuals] are working toward such placement;” or an education program assisting students in obtaining a high school diploma or GED. U.S. Citizenship and Immigration Services. Consideration of Deferred Action for Childhood Arrivals Process. Frequently Asked Questions. <http://www.uscis.gov/humanitarian/consideration-deferred-action-childhood-arrivals-process/frequently-asked-questions#education>
- 2 Misdemeanors are further defined on the U.S. Department of Homeland Security website: <http://www.dhs.gov/deferred-action-childhood-arrivals>
- 3 U.S. Citizenship and Immigration Services. Consideration of Deferred Action for Childhood Arrivals Process. <http://www.uscis.gov/humanitarian/consideration-deferred-action-childhood-arrivals-process#guidelines>
- 4 The term ‘DREAMers’ refers to those who would qualify for the Development, Relief, and Education for Alien Minors (DREAM) Act, which would provide conditional permanent residency for eligible immigrants. The DREAM Act was proposed several times in the U.S. Congress but has not been enacted. In California, a package of state DREAM Act laws extending student financial aid benefits to DREAMers was signed in 2011.
- 5 An additional 127,000 would potentially be eligible if they received their GED. Immigration Policy Center. Who and Where the DREAMers Are, Revised Estimates. October 16, 2012. <http://www.immigrationpolicy.org/just-facts/who-and-where-dreamers-are-revised-estimates>
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- 7 Lucia L, Jacobs K, Dietz M, Graham-Squire D, Pourat N, and Roby DH. After Millions of Californians Gain Health Coverage under the Affordable Care Act, Who will Remain Uninsured? UC Berkeley Center for Labor Research and Education and UCLA Center for Health Policy Research. September 2012.
- 8 Under a bill passed in the U.S. Senate in June 2013 (S. 744), DREAMers (the term used in the bill) would apply for Registered Provisional Immigrant (RPI) Status under a streamlined process. Prior to becoming a Lawful Permanent Resident (LPR), Californians who are granted deferred action under DACA and/or those who gain RPI status would be likely to continue to be eligible for Medi-Cal under current California rules. After DREAMers are in RPI status for at least five years, they would be eligible to apply for LPR status, making them eligible for Marketplace coverage under the ACA or for Medi-Cal under California law. Once DREAMers were granted LPR status, they would immediately be eligible to apply for citizenship. This is just one example of a Congressional proposal. Other proposals involve lengthier paths to citizenship or none at all.
- 9 Under the HHS definition, “lawfully present” includes immigrants granted deferred action for other reasons, such as abused spouses or children who have petitioned for status under the Violence Against Women Act. National Immigration Law Center. “Lawfully Present” Individuals under the Affordable Care Act. September 2012.
- 10 U.S. Immigration and Customs Enforcement. Frequently Asked Questions About Deferred Action for Childhood Arrivals. <http://www.uscis.gov/humanitarian/consideration-deferred-action-childhood-arrivals-process/frequently-asked-questions>
- 11 Federal Register Volume 77, Number 169, Pages 52614-52616 (Thursday, August 30, 2012).
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- 13 Wallace S, Torres J, Sadegh-Nobari T, and Pourat N. Undocumented and Uninsured: Barriers to Affordable Care for Immigrant Population. Commonwealth Fund, 2013.
- 14 Gonzales RG and Terriquez V. How DACA is Impacting the Lives of Those who are Now DACAmented. Preliminary Findings from the National UnDACAmented Research Project. August 15, 2013. <http://www.immigrationpolicy.org/just-facts/how-daca-impacting-lives-those-who-are-now-dacamented>
- 15 California Code of Regulations Title 22 § 50301.
- 16 The California Endowment. Health Coverage Eligibility Worksheet. December 2013. <http://www.acalibrary.org/home/technical-assistance-tools>
- 17 California Welfare and Institutions Code 14011.66.
- 18 U.S. Immigration and Customs Enforcement. Clarification of Existing Practices Related to Certain Health Care Information. October 25, 2013. U.S. Department of Health and Human Services. What do immigrant families need to know about the Marketplace? <https://www.healthcare.gov/what-do-immigrant-families-need-to-know/>

- 19 County-specific income eligibility standards and services covered are detailed in this report: Health Access Foundation. California's Uneven Safety Net: A Survey of County Health Care. November 2013. <http://www.health-access.org/files/expanding/California%27s%20Uneven%20Safety%20Net%20-%20A%20Survey%20of%20County%20Health%20Care.pdf>
- 20 Income eligibility standards for these programs can be found on the following websites: Los Angeles County Department of Public Social Services, Outpatient Reduced-Cost Simplified Application (ORSA) Plan, <http://www.ladpss.org/dpss/health/orsa/default.cfm?persona=family>. Los Angeles County Department of Public Social Services, Ability-To-Pay (ATP) Plan, <https://dpss.lacounty.gov/dpss/health/atp/default.cfm?persona=aged>
- 21 The Low Income Health Program (LIHP) was a county-based coverage program for low-income uninsured adults included in California's "Bridge to Reform" §1115 Medicaid Demonstration Waiver. On January 1, 2014, more than 630,000 Californians who were enrolled in LIHP became newly eligible for Medi-Cal under the Affordable Care Act and were transitioned to Medi-Cal coverage. California Department of Health Care Services. News Release: California's Low Income Health Program Transitions Hundreds of Thousands of New Members to Medi-Cal. December 31, 2013.
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- 23 Kaiser Permanente. Child Health Program. http://info.kaiserpermanente.org/html/child_health_plan/index.html. Trotman J and Perry A. Kaiser Permanente Child Health Plan Training. Powerpoint presentation updated September 16, 2013.
- 24 An additional 127,000 would potentially be eligible if they received their GED. Immigration Policy Center, 2012.
- 25 The Immigration Policy Center estimated that 298,000 Californians were immediately eligible for DACA in 2012. As of December 2013, 154,000 Californians' applications for DACA had been approved, according to U.S. Citizenship and Immigration Services.
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- 33 Access for Infants and Mothers, What Services are Covered in AIM? <http://www.aim.ca.gov/Services/>
- 34 Use of Medi-Cal long-term care services could affect the government's decision about whether or not an individual is considered a "public charge," which could potentially affect the ability to adjust to lawful permanent residence.
- 35 California HealthCare Foundation. Medi-Cal Facts and Figures: A Program Transforms. May 2013.
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- 37 National Immigration Law Center. Major Benefit Programs Available to Immigrants in California. October 2013. www.nilc.org/document.html?id=481
- 38 The California Endowment. Health Coverage Eligibility Worksheet. December 2013. <http://www.acalibrary.org/home/technical-assistance-tools>
- 39 Health Initiatives of the Americas, UC Berkeley School of Public Health. Guide to Health Programs: A Bilingual Resource to Help Find Free or Low-Cost Health-Related Programs for You and Your Family. 2012-2013 (10th Edition). <http://www.chcf.org/resources/download.aspx?id=%7b264818DB-A3F6-44BC-9AC8-482C4EA5202D%7d>



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