A Golden Opportunity

Lessons from California on Advancing Coverage for All Children

The Children's Partnership

CHILDRENSPARTNERSHIP.ORG

January 2018

The Children's Partnership is a nonprofit, advocacy organization that works to improve the lives of children where they live, learn, and play. Since 1993, we have worked to advance the health and well-being of underserved children in California and in the country through meaningful community partnerships, forward-thinking research, and community-informed policy.

Contents

Foreword

CALIFORNIA'S demographic and political shift has led to remarkable progress on health coverage for children in immigrant families. In 1994, less than 25 years ago, California voters passed Proposition 187, which sought to prohibit undocumented immigrants from using non-emergency health care, public education, and other services. Yet, in 2015, the governor of the same state signed a law to provide health coverage to all children regardless of immigration status. Proposition 187 was eventually overturned by a federal district court, but not before doing serious emotional and psychological damage to the communities it targeted. The aftereffects of both the measure and the surrounding rhetoric had long-lasting impacts on the 2 million undocumented immigrants living in California at the time and particularly on immigrant families' utilization of health care.

Today, a climate of fear and uncertainty is causing similar concerns about health care access for immigrant families. The change in federal administration and the marked rise in threats and activities targeting immigrants for detention and deportation—coupled with the subsequent efforts to repeal the Affordable Care Act, cut Medicaid, and delay reauthorization of the Children's Health Insurance Program (CHIP)—have had devastating implications for California's hard-fought victories in securing health coverage coverage for an estimated 98 percent of California's children and youth, including those who recently gained health care access through the passage of the Health For All Kids Act (Lara, D-Bell Gardens) in 2015.

At The Children's Partnership, we recognize the critical importance of defining issues from a children's perspective in order to deploy a more humane approach to policymaking. As we reflect on the decades-long journey of California to this position of inclusion, we will seek to build on this progress and ensure the well-being of all of California's children and their families.

The following pages not only provide a look at the steps that led California to coverage advancements for children but also provide universal lessons for future social change. While every state is unique in its approach, we hope these insights can be adapted to fit the specific circumstances in a variety of other states and localities. This document calls on our continued commitment to support the health and well-being of all Californians and, ultimately, all Americans, no matter where they are born. As these 25 years have shown, the arc of the moral universe is long, but it does indeed bend toward justice. We remain hopeful in our shared commitment to the future of all our children and look forward to working together to put our values into action.

In solidarity,

Mayra Alvarez

Mayra E Alvarez MHA

Introduction

HEALTH INSURANCE coverage and access to health care are important tools to ensure the health and well-being of children and their families in California and across the country. Children with health coverage—and particularly public health coverage provided by programs like Medicaid and CHIP, known jointly in California as Medi-Cal—become healthier adults, are more likely to finish high school and graduate from college, and have higher incomes and contribute more in taxes.[1]

As a result of California's commitment to the Affordable Care Act (ACA), Medicaid, the Children's Health Insurance Program (CHIP), and additional state expansions in coverage, almost every child in California has access to the security that health insurance provides. Regardless of place of birth, a child in California is likely to qualify for federally or state-funded programs that offer free or low-cost coverage. With the enactment of the Health for All Kids Act, California now provides health care coverage for an estimated 98 percent of children.[2]

Expansions of coverage under the ACA, efforts to reduce barriers to enrollment and reenrollment, and state-funded expansions like SB 75 have positioned California as a leading state in health coverage for children

At the same time, the state and local counties have made concrete efforts to support immigrant families in California. In 2013, California passed a law to provide driver licenses to state residents, regardless of immigration status.[3] Building on this step forward, in 2014, the governor signed a bill to

provide professional licenses (such as barbers, cosmetologists, doctors, and nurses) to state residents regardless of immigration status.[4] In addition, a number of local governments invested in health coverage programs—like Healthy San Francisco and My Health LA—to provide health care services to adults living in the city or county.[5] Each of these efforts provides families with the resources and tools to get to work, stay healthy, and provide for their children.

Expanding health coverage is not just a simple provision of a public benefit but rather a strategic investment that will strengthen tomorrow's workforce and ensure the economic future of the nation. The Center for American Progress states that, with an estimated 83 million individuals needed both to replace an aging workforce and create new growth, immigrants and their children will be critical to the growth of the American workforce and economy.[6] Given this economic need, efforts undertaken by California and other states to expand health care coverage for all children, regardless of immigration status, become especially crucial. According to The National Immigration Law Center, as of July 2017, five states and Washington, DC, have expanded coverage to all children, regardless of immigration status, indicating a national trend responsive to the evolving needs of American families.

After the passage of the Health for All Kids Act in California, advocates working towards similar goals in other states expressed interest in the key elements that led to this accomplishment. Also during this time, a California coalition of local and state organizations began working on long-term strategies to preserve the advances made in health care coverage for all children, as well as protect Medicaid and the Affordable Care Act—the underlying government programs upon which those advances were built.

The Children's Partnership set out to examine how states can best develop

a comprehensive children's coverage policy by examining the journey undertaken by one state in particular. In many respects, California offers a glimpse of the nation's future—both the challenges that lie ahead and the opportunities that other states can utilize.

With this in mind, The Children's Partnership interviewed numerous stakeholders who played key roles at various stages of California's 20-year effort to cover all children; the quotes throughout this brief represent their voices. To gain a wider perspective on the various strategies for sustaining programs and maximizing enrollment, The Children's Partnership also interviewed advocates from other states that have either been running or are in the process of developing similar programs covering undocumented immigrant children, such as Oregon, Illinois, Washington, and Massachusetts. The report also includes information from California Coverage & Health Initiatives (CCHI) enrollment assisters' experience, as well as Children Now's 2017 survey of community organizations and providers.[7]

This report distills a number of key elements that are valuable in two respects:

- For states considering an expansion of health care coverage to all children, regardless of immigration status, this paper highlights strategic considerations for pursuing expansion, as well as challenges that must be taken into account.
- For states like California that have succeeded in expanding coverage to all children, this paper also emphasizes a number of important activities that both policymakers and advocates must prioritize to ensure that these gains are not lost and further progress is made to support all children, regardless of where they are born.

As California and other states seek to advance an agenda responsive to the needs of children, these findings help illustrate where consensus and public will can be gained to further the success of expanding coverage to all children and ensure the safety and security of all families.

California's Journey to Covering All Children

AS IS OFTEN THE CASE with most major policy changes, health care coverage for all children in California did not occur instantly, but incrementally, and with different coalitions and partnerships leading and engaging in the work along the way. The state's journey towards this goal over the past 20 years may be viewed as a single "campaign," where multiple stakeholders throughout the state—advocates, health care providers, lawmakers, and others— worked at different time periods and at different levels (e.g., county, regional, or state) to advance the shared vision of ensuring health care coverage for all children.

This progression is characterized as several often overlapping phases: the establishment of California's own CHIP program, the development of local and county-based initiatives to provide coverage to all children, a larger movement to secure a state-based insurance program for children, and the quest to cover the remaining uninsured after the passage of the Affordable Care Act.

CHIP Gets the Ball Rolling

The passage of the State Children's Health Insurance Program (SCHIP) in 1997 sparked interest in making available a coverage program for every child. The program made accessible significant federal matching funds to states to provide health coverage to low-income children in families with incomes too high to qualify for Medicaid but who could not afford private coverage.

That same year, California lawmakers quickly leveraged SCHIP funding by establishing the Healthy Families Program. The new program complemented the state's own Medi-Cal for Children, such that the two programs were able to provide comprehensive health care coverage to a wider range of uninsured children.[8] State leaders sought to further reduce the number of uninsured children

in California through a number of program changes, such as expanding income eligibility levels and utilizing Medi-Cal income deductions in determining eligibility.[9]

Local Coverage Efforts Ramp Up

Encouraged by the success of Healthy Families, local advocates set their sights next on expanding health care coverage to more children. A number of previous initiatives, such as CaliforniaKids and Kaiser Cares for Kids, had experienced some success in improving access to care, but they were only able to cover a modest number of children. As a result, community stakeholders, local health departments, health care plans, and foundations in counties across the state began discussing how best to ensure that more children in their community had access to quality health care through comprehensive health insurance.

In Santa Clara County, these discussions led to the creation of the first Children's Health Initiative (CHI), a county-based coalition that sought coverage for 100 percent of the county's children. To accomplish this goal, two major activities were prioritized: the expansion of current outreach and enrollment efforts to uninsured children and their families, as well as the development of a heavily subsidized, private insurance product for children who did not qualify for Medi-Cal or Healthy Families.[10]

Santa Clara's establishment of a Children's Health Initiative paved the way for other localities to create their own programs. In the years that followed, 28 CHIs were established to serve 30 counties; 21 of these provided a Healthy Kids insurance product, while others provided coverage through a CaliforniaKids product.[13] As progress was made in reducing the number of uninsured children, political support grew. Encouraged by the achievements of local CHIs, state lawmakers worked with health advocates to bolster these efforts through legislation that sought to secure a federal match for eligible children enrolled into local insurance programs.[14]

Despite the substantial gains made in increasing coverage for children throughout California, CHIs soon encountered challenges in maintaining their efforts without sustainable long-term financing. By 2009, the number of counties with Healthy Kids programs declined sharply to 15; of those counties, four had waitlists totaling 6,808 children.[15] Other programs, including L.A. County's Healthy Kids, opted to implement an "enrollment hold" for children 6-18 years of age beginning in 2005, leaving this age group without access to full health care.[16]

Pursuit of a State Solution

Health advocates recognized early on that coverage initiatives relying on charitable support would have difficulty achieving long-term sustainability. As a result, local efforts simultaneously sought to maintain local programs while also securing support for a statewide

Healthy Kids Santa Clara

The launch of Santa Clara's *Healthy Kids* program in 2001—which covered children whose family income was just above Medicaid and CHIP levels or were not eligible due to immigration status—paved the way for other localities to create their own programs. Healthy Kids was locally funded through a public-private partnership and was administered through the Santa Clara Family Health Plan (SCFHP), the county's local initiative under the two- plan model.[11]

At the time, approximately 10 percent of children in Santa Clara lived below the federal poverty level (FPL), while another 40 percent lived below 300 percent of the FPL. According to a 2005 report, among those children living in poverty, an estimated 70 percent were Latino, and almost all had at least one non-citizen parent—characteristics that were closely associated with low rates of insurance coverage.[12]

system of coverage. With the support of key philanthropic partners, in 1997, three organizations—The Children's Partnership, Children Now, and Children's Defense Fund-California—joined forces to create The 100% Campaign, with the goal of ensuring that all of California's children obtain and retain the health coverage they need to grow up strong and healthy. The Campaign partnered with PICO California, United Ways of California, and the California Coverage & Health Initiatives (CCHI) —a coalition of CHIs—to seek expansion of statewide coverage to all children.[22]

Although progress was made in expanding the number of local efforts,[23] there were challenges as well. In 2005, Governor Arnold Schwarzenegger vetoed legislation that would have expanded eligibility and improved efforts to enroll children eligible for the state's Healthy Families program or Medi-Cal.[24] The following year, a bid to secure $23 million in state funding for 18 local Healthy Kids programs was rejected,[25] and a ballot measure that would have funded statewide children's health insurance through an increase in tobacco taxes was narrowly defeated.[26]

In 2007, Governor Schwarzenegger unveiled his own plan that would require all Californians to have health insurance. Under this proposal, all uninsured children below 300 percent of the federal poverty level would be eligible for state-subsidized coverage, regardless of residency status.[27] Unfortunately, Governor Schwarzenegger's health care reform proposal died in the legislature after a vigorous year of debate when its estimated cost of $14.9 billion was weighed against the state's already $14.5 billion budget deficit.[28] In 2008 and 2009, budget deficits continued to weigh on California, which faced shortfall estimates of $24 billion through state fiscal year 2010.[29] Subsequent efforts in the state legislature to resurrect coverage for children similarly failed, as the economic recession took its toll on public health care programs. The years to follow saw heavy cuts to Medi-Cal and a temporary enrollment freeze in Healthy Families due to state budget shortfalls.[30]

Summary of Local Coverage Initiatives

CaliforniaKids (1992)

Funded through charitable contributions and premiums paid by members, CaliforniaKids offers insurance to children ages 2 to 8 who are ineligible for Medi-Cal; in 2006, virtually all of the children covered by the program were undocumented. Benefits are limited to outpatient services, but include behavioral health, dental, prescription drug coverage.[17, 18]

Kaiser Permanente Child Health Plan (1998)

Also known as Kaiser Cares For Kids, this subsidized program is funded by Kaiser Permanente of California. All families regardless of income level have to pay monthly premiums, are required to obtain services at the health plan's facilities, and are not covered for care received at other sites in the community. Program enrollment opened and closed intermittently, based on funding. Undocumented immigrant children are eligible for coverage if they meet income eligibility criteria but must live in a Kaiser service area. [19]

Healthy Families (1998)

California's SCHIP program provides coverage up to 250 percent FPL. The program was folded into Medi-Cal in 2013.[20]

Healthy Kids (2001)

Initiated at the county level by Children's Health Initiatives (CHIs), Healthy Kids was a local insurance product providing comprehensive benefits for children from families with incomes slightly higher than statewide CHIP, and who were ineligible for both public and employer-sponsored health insurance.[21]

ACA: The Game-Changer

The enactment of the Affordable Care Act made possible tremendous opportunities to expand coverage in California and across the nation. The insurance reforms, coupled with federal financing for coverage, provided substantial investments in Medicaid expansions for adults and premium tax subsidies for middle-income families, including children with incomes above the Medi-Cal and CHIP levels up to 400 percent of the federal poverty level, to purchase insurance through the Health Insurance Marketplaces. Children also benefited greatly from some of the insurance reform provisions, such as prohibition on underwriting and exclusion due to pre-existing conditions, extending Medicaid coverage for those foster care children who aged out of Medicaid, and requiring employers to continue offering coverage to workers' children up to the age of 26.

Simultaneously, the passage of the ACA shifted California to a culture of coverage for its residents. Beyond the expansion of health care coverage, California also committed to consumer protections, quality

improvement, and accessible health care. While the coverage expansions for children in the ACA were modest in comparison to those for adults, the law also had significant impact on children's health coverage and opportunities to improve the overall health of children in the state.

To maximize the new ACA opportunities, California ended its Healthy Families program and transitioned the program's estimated 870,000 children into Medi-Cal, while maintaining the increased income thresholds to ensure beneficiaries' continuity of coverage.[31] Today, California utilizes CHIP funding to support full-scope Medi-Cal for children who would have been eligible for Healthy Families, pregnancy-related services through the Medi-Cal Access Program (MCAP), and three county-based programs.[32]

As a result of California's leadership in implementation, enrollment numbers increased, and the uninsured rate for children dropped from 9.5 percent to 5.4 percent between 2009 and 2014.[33] By providing coverage for more adults, the law created a pathway for enrolling already eligible uninsured children into coverage. Studies show that increasing coverage for parents also increases the number of children with health coverage, creating what's known as a "welcome mat" effect for children.[34] The availability of coverage for the whole family, enrollment simplifications, inclusion of free preventive services, mandated essential pediatric health benefits (including pediatric oral and vision services), investments in outreach and enrollment, and other provisions of the ACA cemented California's leadership in providing coverage.

The ACA's culture of coverage in California, coupled with an improved economic outlook, opened up new opportunities for funding further coverage expansions to include the remaining uninsured. In California, the remaining uninsured were overwhelmingly undocumented, and federal rules still prohibited comprehensive coverage for undocumented immigrants, including children. While the ACA expanded Medi-Cal health coverage to approximately 3.5 million Californians by 2015,[35] it excluded an estimated one million low-income adults and some children who were ineligible because of their immigration status.[36]

A Solution for California's Undocumented Immigrant Children

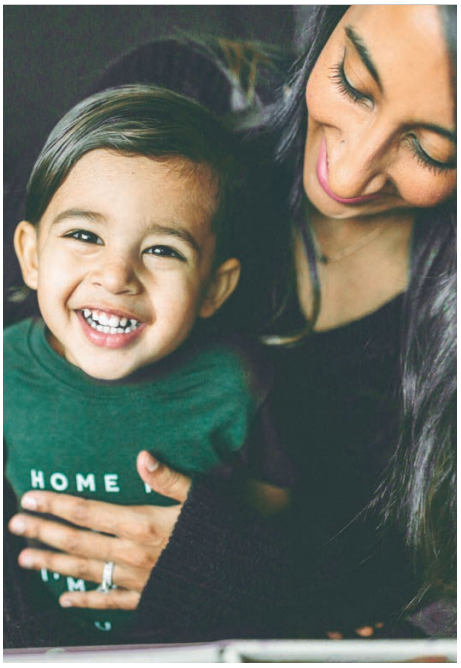
In 2014, a group of immigration and health care advocates, including Health Access of California and the California Immigrant Policy Center (CIPC), created the Health for All Coalition to increase health insurance opportunities for those remaining Californians who did not have coverage options. The Health for All Coalition was comprised of consumer, community, immigrant, labor, and health care organizations, such as community health centers, working to advance the goal of health coverage for all Californians.

That same year, the Health for All Coalition, working with State Senator Ricardo Lara (D-Bell Gardens), introduced SB 1005, legislation that would have expanded access to health care coverage for all Californians, regardless of immigration status. The bill would have authorized enrollment in Medi-Cal, or in an insurance program offered through a new, separate health benefit exchange, to individuals who would otherwise qualify for enrollment in those programs but were denied based on their immigration status.[37] The individual organizations comprising the Children's Coalition joined the Health for All Coalition's call for passage of SB 1005 to emphasize the fact that children are more likely to be covered and receive services if their parents have coverage. Unfortunately, the bill stalled in committee.

The following year, another attempt was made when Senator Lara introduced similar legislation, SB 4, to continue the effort to provide coverage to every Californian. While the legislation began as a comprehensive bill to expand coverage to all Californians regardless of immigration status, it became clear that the legislation was unlikely to

move forward. In an attempt to advance the effort through budget negotiations, Senator Lara decided to amend the bill into two parallel efforts: a commitment to an ACA Section 1332 State Innovation Waiver for covering undocumented adults and a Medi-Cal expansion for undocumented children. In the end, only SB 4's expansion of Medi-Cal for undocumented children was included in the 2015-16 budget bill. In June 2015, the legislature and Governor Jerry Brown approved SB 75, a budget bill that, in part, made children under age 19, up to 266 percent of the FPL, who do not meet satisfactory immigration status but meet all other eligibility requirements, eligible for Medi-Cal. SB 4 was subsequently amended and signed in October 2015 to create a smooth transition for those children in limited-scope Medi- Cal into full-scope Medi-Cal.[38] The limited expansion was a significant disappointment for the Health for All Coalition. The extensive organizing and contribution by immigrant groups to the health care debate had not reached its intended goal of universal coverage for all Californians, regardless of immigration status. However, after acknowledging the victory for children and the opportunity to learn from implementation, the Health for All Coalition rallied behind the expansion for children and used it as an opportunity to continue to advocate for every member of the family to have access to coverage.

More than one year after its "go live" date in May 2016, the SB 75 expansion has led to comprehensive Medi-Cal coverage for approximately 216,000 of the 250,000 estimated eligible undocumented children in California.[39, 40] An estimated 44 percent of these children are new enrollees in the program, while another 56 percent were transitioned from limited-scope Medi-Cal.[41] Including coverage of this additional population, California now provides health care coverage for



an estimated 98 percent of children. Expansions of coverage under the ACA, efforts to reduce barriers to enrollment and re-enrollment, and state-funded expansions like SB 75, have positioned California as a leading state in health coverage for children.[42]

A Timeline of Children's Coverage in California

1997 The **State Children's Health Insurance Program (SCHIP)** is signed into law.

1998 California establishes the **Healthy Families Program (HFP).**

2001 Santa Clara County establishes the first **Children's Health Initiative (CHI).**

Santa Clara CHI implements its new **Healthy Kids** program.

2005 **AB 772** (Chan) to cover all children is vetoed for lack of funding.

2006 Budget funding for local **Healthy Kids** insurance fails.

Tobacco Tax ballot initiative including coverage for all children narrowly fails.

2007 Governor Schwarzenegger's health reform effort which included coverage for all children fails in the Legislature.

2009 Federal government reauthorizes SCHIP as the **Children's Health Insurance Program (CHIPRA).**

2010 President Obama signs into law **The Patient Protection & Affordable Care Act**, also known as the **Affordable Care Act (ACA).**

2013 Healthy Families (CHIP) children transition to Medi-Cal.

2014 **Covered California** coverage begins for families, including 80,000 children.[43]

SB 1005 to expanded health care coverage for all Californians, regardless of immigration status, stalls in committee.

2015 Governor Brown signs **SB 75,** the health budget trailer bill that extends full-scope coverage to undocumented children.

2016 **Health4All Kids (SB 75)** begins to enroll children.

California is America Fast-Forward

Children in Immigrant Families as the State's Future and the Nation's Future

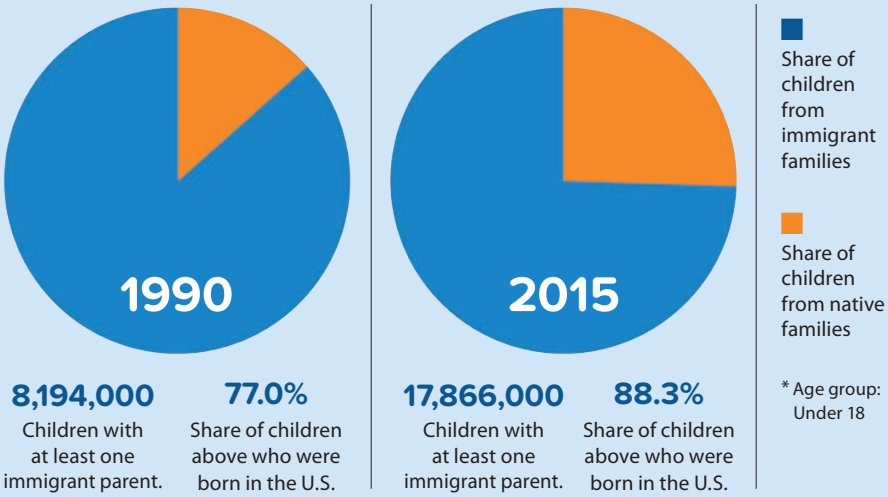
THE WELL-BEING OF children in immigrant families is especially important to the nation because they are one of the fastest-growing segments of the U.S. population. In 2015, one in four youth aged seventeen and under lived with an immigrant parent, up from 15 percent in 1990.[44, 45]

The children of immigrants made up one-quarter of all children nationwide and accounted for all growth in the child population between 2006 and 2014.[46] Today, approximately half of all California's children—roughly 4.5 million—live in immigrant families.[47] While the majority of immigrant children's families come from Mexico, Asia, and Central America, California is also home to immigrants from Europe, South America, the Caribbean, and Africa.[48] In fact, the majority of Californians are people of color, with three in four children identifying as a racial or ethnic minority.[49]

One of the biggest elements in this shift in demographics is the growth in the Latino population in recent decades. In 1970, an estimated 2.4 million Latinos in California accounted for 12 percent of the state's total population; in contrast, there were approximately 15.5 million Caucasian residents, roughly more than 75 percent. But by 1990, the Latino population had jumped to 7.7 million (25 percent) and by 2014 had matched the number of Caucasians. Further, of the 9 million children in California, more than 50 percent identify as Hispanic/Latino.[51] State demographers project Latinos will account for an estimated 49 percent of Californians by 2060.[52] Although the vast majority of California's immigrants were born in Latin America, the majority of recent arrivals in California come from Asia, with sizeable populations from China, the Philippines, India, and Vietnam.[53] And, Asians have become a majority in more than half a dozen cities in Southern California—particularly in the San Gabriel Valley—in the last decade.[54] The connection between demographic changes and political shifts is critical to the progress seen in California and will continue to influence policy.

In particular, the substantial shift in Latino demographics has become relevant for two major reasons. First is the corresponding shift in political power and leadership in California over the last twenty years. Demographic changes provide an opportunity for critical transformation of the political structure. Specifically, as immigrants naturalize and become citizens, they can more effectively seek to end barriers to essential resources like education and health care for themselves and their children.[55] (See Box: Health Care and the Power of Representation.) Second, the increase in the number of immigrants has become a major driver in California's economy. State leaders in both the public and private sectors recognize that California's long-term future depends on the children of immigrants who will be an increasingly large part of the workforce.[56] The California Chamber of Commerce has noted that a number of the state's economic sectors—including the technology, agriculture, and tourism industries—are dependent on immigrant labor. Also, California's agricultural economy has continued to

Children* in U.S. Immigrant Families:
The Number and Share of the Total U.S. Child Population[50]



8,194,000 Children with at least one immigrant parent.

77.0% Share of children above who were born in the U.S.

17,866,000 Children with at least one immigrant parent.

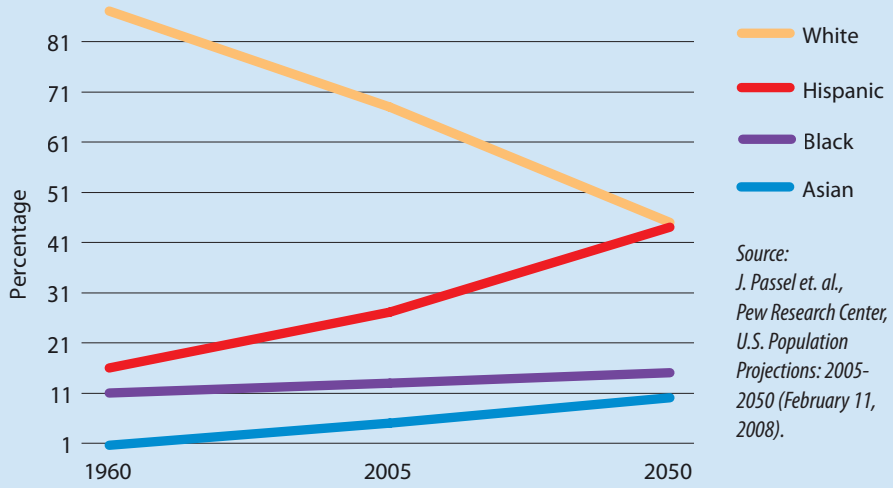
88.3% Share of children above who were born in the U.S.

rely heavily on immigrant labor.[57] State Controller Betty Yee has stated that undocumented immigrants' labor is worth more than $180 billion a year to California's economy—roughly on par with Oklahoma's 2015 GDP.[58]

But this change in demographics isn't limited to California, a state once referred to as "the harbinger of demographics... of the nation to come."[59] Manuel Pastor—a professor at the University of Southern California and a keen observer of a changing California—put it more succinctly: "California is America fast-forward." He notes that the social and economic changes experienced by California between 1980 and 2000 is what the U.S. is projected to experience between 2000 and 2050.[60]

Like the Golden State, the rest of the U.S. is experiencing similar shifts. According to the Pew Research Center, an estimated 43.2 million immigrants—roughly 13.4 percent of the nation's population—resided in the U.S. in 2015. In contrast, there were only 9.7 million immigrants living in the U.S. in 1960, accounting for just 5.4 percent of the U.S. population.[61] In the next five decades, the majority of U.S. population growth is projected to be linked to new Asian and Latino immigration.[62] Latinos currently make up 16 percent of the overall U.S. labor market and will account for one out of every two new workers entering the workforce by 2025. Moreover, 66,000 Latinos are turning 18 each month.[63] By 2050, nearly half of the U.S. workforce will be Hispanic or Asian, and the children of immigrants nationwide will be among the strongest economic and fiscal contributors in the U.S. population.[64] As such, equipping children in immigrant families with the tools and resources necessary to thrive is critical for the nation's economic future.

Percentage of Working Age Population in the U.S. by Race and Ethnicity

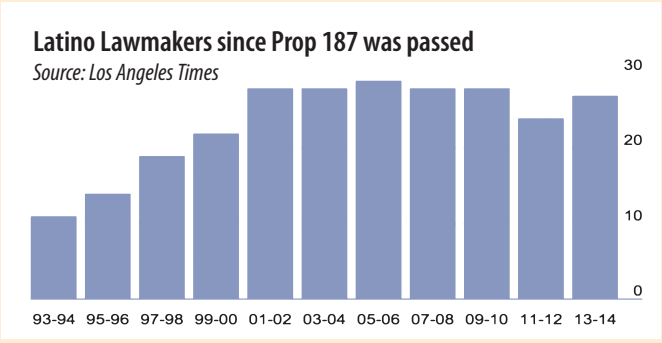


Source: J. Passel et. al., Pew Research Center, U.S. Population Projections: 2005-2050 (February 11, 2008).

Health Care and the Power of Representation

The fight to expand health care to all immigrant families was aided in the political realm by two factors. First was the shift in demographics in the state legislature. By 2016, Latinos represented 20 percent of California's lawmakers, empowering the Latino Caucus as a major driver of progressive causes. Thirteen of its members were chairs or vice chairs of legislative committees, while five members held leadership appointments. The second relevant factor was the change in term limits for California legislators resulting from the passage of Proposition 28 in 2012. Under stricter term limits in the past, members were far more beholden to leadership and their party caucus. With the passage of Prop 28, the new ability to serve up to 12 years in the legislature afforded individual members greater political independence and leeway to pursue individual priorities.

Given these changes, Latino leadership was able to spearhead bills that addressed educational disparities and voter access, strengthened clean energy rules, and asserted immigrant rights. In particular, Senator Ricardo Lara—the son of immigrant parents raised in East Los Angeles and elected into office in 2010—was the prime mover of legislation that ultimately led to Health4All Kids.



Lessons from California's Road to Coverage for All Children

AS LEADERS—BOTH inside and outside of government—continue to press for California to provide health coverage for all, build policies to protect immigrant families from inhumane federal immigration policies, and forge progress on other needed social change, The Children's Partnership wanted to take stock and share lessons learned from California's 20-year effort to gain coverage for all children.

In order to identify and validate these lessons, The Children's Partnership interviewed stakeholders who played key roles at various stages of California's effort. This included people who provide direct health care and other services to immigrant families, advocates for health care for children and families, key staff at philanthropic organizations that supported coverage for children, people in state and local government roles, and advocates in other states that either cover undocumented immigrant children or are working to do so. We observed that the key strategies that were instrumental in achieving this accomplishment were also the critical elements for sustaining this effort and making further progress. The following lessons learned not only share how California got here but also identify the work needed to sustain this achievement and push for additional progress.

> **"We sustain a commitment to 'covering all kids' in the context of equity plus strong agency commitment and strong community advocacy and leadership..."**

LESSON #1:

Build Support from the Ground Up

How Did We Get Here?

The needs of families and communities at the local level were a major driver of change. The identification of a problem at the neighborhood, city, or county level often leads to widespread changes at the state and national level. In a similar vein, when California counties such as Santa Clara began to develop outreach strategies to encourage families to enroll in CHIP in the 1990s, they had already identified that the program would not adequately address the issue of health care coverage for all children. From these initial conversations came the idea for Children's Health Initiatives dedicated to ensuring that all children receive comprehensive health coverage.

The success of innovative coverage programs in local communities helped elevate the health care conversation to the state and national levels. In addition to local leadership driving statewide change, the local programs themselves served as critical demonstrations, showcasing how covering all children across the state can be done. The success of programs like Healthy Kids provided alternative models of coverage that demonstrated ways of performing trusted and effective outreach, coverage design, care utilization, and cost efficiencies. In doing so, they set the stage for conversations at the state level.

Grassroots advocacy was key to propagating solutions. CHIs started with and were sustained by grassroots advocacy and local community leadership. Foundations, health care plans and providers, and county departments joined forces with educators, faith-based organizations,

unions, local businesses, and health care consumer advocates to form coalitions that would plan, finance, and implement children's health insurance programs targeting efforts at the local level.

Some interviewees noted that many of these local partners came together not because they would benefit from the work, but because they shared a common belief: covering all kids was the right thing to do. The commitment of these local leaders was not only pivotal to creating their respective local programs but in advancing and ultimately securing a statewide system of coverage for all children. Moreover, the engagement of local partners also created a network of community-based advocates in more than 30 counties to meet with state legislators on the importance of providing coverage to all children. Advocates were representatives of the communities implementing expansions and could speak to the experience of the families directly affected in their districts—an effective tool when educating policymakers.

The building of local partners to support the expansion of coverage to children regardless of immigration status was furthered by the contribution of immigrant rights groups. The California Immigrant Policy Center (CIPC) acknowledged the shift in public opinion and moved to personalize the issue for the public and draw attention to the stories of children and families that were left out of available options for coverage. In 2014, CIPC spearheaded the Undocu-CARE-Van, which traveled from San Diego to Sacramento to build momentum, frame health care as an immigrant issue, and create awareness across the state about legislation supporting health coverage for people ineligible because of immigration status. Participants included immigrants, health advocates (such as community health center staff and patients), and other allies in the effort. The caravan journey was divided into six regional stops, which included San Diego, Orange County, Los Angeles, Inland Empire, Fresno, and Sacramento. While a statewide effort, the journey focused on specific areas to engage growing immigrant communities, target key elected officials, and make the most of the political shift. Specific areas were targeted to build on the momentum immigrant rights groups had built in the previous year through legislative wins like driver licenses (AB 60) for the undocumented and the TRUST Act (AB 4), legislation that further solidified the shift in political attitude towards immigrants in California. Communities had seen the power of civic engagement play out in the previous year and the exclusion of undocumented immigrants from the Affordable Care Act was an opportunity to continue to address the injustices and adversity faced by immigrant families.

> **"Community-initiated effort and community leadership drive the body politic."**

Local initiatives also played a key role in moving the needle locally from the toxic conversation of anti-immigrant sentiment to a "new normal" of acceptance and inclusion, even in more traditionally conservative counties. This neighbor-to-neighbor approach was far more effective than a statewide effort to shift the conversation frame from anti-immigrant to inclusion.

The Work Ahead

Continue to nurture/bolster support for Health4All in local communities. As noted previously, the Health4All campaign was built on local grassroots advocacy, particularly local immigrant rights coalitions. Local leaders and community coalitions for children and immigrants continue to be critical assets in any effort to sustain momentum for enrolling children in California's Health4All Kids and keeping the program strong. Their voice is also needed in efforts to defend Medi-Cal from state or federal cuts and to

continue to extend coverage to young adults and other Californians who remain uninsured.

The recent rescission of the Deferred Action for Childhood Arrivals (DACA) program necessitates California's continuing to ensure that DACA recipients, former recipients, and those who would have become eligible have access to health coverage. On September 5, 2017, the Trump Administration announced that it was terminating the DACA program.

Although the Department of Homeland Security has stopped accepting new DACA applications, some people who applied by October 5, 2017, will receive a two-year renewal of work authorization and relief from deportation. However, others will lose status and with it their work authorization and possibly employer-based coverage. Although people with DACA status are not eligible for federally funded marketplace, Medicaid, or CHIP coverage under federal law, California has provided *state-funded* coverage for them under its longstanding policy of providing coverage for people residing under color of law (PRUCOL). The California Department of Health Care Services has indicated that it intends to continue to provide state-funded coverage for DACA recipients or those who lose DACA. However, advocacy is needed to secure affordable health coverage on behalf of those who would have become eligible for DACA but can no longer apply and are too old to be eligible for Health4All Kids.

LESSON #2:

Start with the Big Goal and Stay the Course

How Did We Get Here?

Policy change was advanced via different vehicles. Advocates working to expand coverage quickly learned to be flexible and consider all available vehicles for policy change, including finding financing options. In 2005, AB 772 (Chan; D-Oakland) was an important effort to try and move coverage for children forward. Although Governor Schwarzenegger vetoed AB 772 due to funding, children's advocates sought to get funding (and were unsuccessful) through a budget line item. Another opportunity arose the following year when Proposition 86—a tobacco tax initiative intended to fund various health programs, including children's health coverage—gained enough signatures to be on the ballot due to smart partnerships and PICO's powerful grassroots ground game. After Prop 86 narrowly failed, children's coverage was incorporated into another vehicle the following year, namely Governor Schwarzenegger's health reform effort. In 2015, interviewees pointed to the flexibility of the authors of Health4All legislation when they accepted and subsequently championed the compromise of covering undocumented immigrant children instead of all remaining uninsured undocumented immigrants. This afforded the opportunity to make an incremental step forward for children's coverage.

Numerous attempts to change health care policy provided invaluable learning experiences along the way. Advocates understood that winning health care coverage for all children was not going to be one quick and easy win. As a result of several attempts to change health care policy at the state level, advocates developed a better understanding of what did and did not work in terms of strategy, public opinion, and policy.

> **"Persistence was the political characteristic that was most important to success."**

One example comes from the changing tactics utilized to secure coverage for undocumented immigrant children. Early efforts explicitly advocated coverage for this specific group, with the CEO of the Santa Clara Health Plan declaring, "We didn't care whether they had a green card, a blue card or whatever color card—a kid is a kid." Later attempts shifted the emphasis away from the immigration status of a child and towards a larger umbrella of "all kids," as was the case in the 2006 Prop 86 effort, as well as Governor

Schwarzenegger's 2007 health care reform proposal.

The "all kids" strategy proved problematic. When opponents criticized coverage for undocumented immigrants, proponents who were not clear upfront about coverage for undocumented children were put in a defensive posture. After the ACA filled in many of the coverage gaps for children who were citizens or legal immigrants, the remaining uninsured were predominately undocumented immigrants. As a result, advocates switched gears once again and were more explicit in championing the expansion of health care to undocumented immigrants. Multiple interviewees commented on how this clarity in framing is particularly relevant to the work ahead. The decades of work of coverage initiatives for children made clear the importance of framing and building incremental support for sustainable change. As such, the baseline for children's coverage shifted and so, too, did the expectations for children's coverage throughout the state. Similarly, as we look to further expansions for California families, the broad frame is necessary.

The Work Ahead

California's "history of incrementalism" can get us to Health4All by building on its current system and continuing to make advancements. In an effort to advance coverage for all remaining uninsured, particularly all immigrants, coverage for immigrant children is but the first step in strategic incrementalism. Today, most low-income adults who are not "lawfully present" are ineligible for federally funded health care programs (other than limited-scope Medicaid for emergency medical conditions). California already provides state-funded coverage for the lowest income adults in a PRUCOL category; however, others who are not lawfully present do not have affordable coverage options. Building on the success of Health4All Kids, members of the Health4All Coalition launched a campaign to provide Medi-Cal coverage for young adults, regardless of immigration status. The proposal sought to invest a small portion of the expected $1.2 billion tobacco tax revenue from California's Proposition 56. While the campaign was ultimately not successful, the effort was evidence of (a) the mobilization power of the Health4All Coalition and (b) the continued political opportunity to push further expansions for California families.

Working for universal coverage, whether at the local level or on long-term, statewide planning, campaign efforts must continue. As noted in the trajectory above, California has always moved the needle ahead in health care. Before the ACA, California attempted its own health care reform. While not advancing, it did expand the dialogue on health coverage and access. At the passage of the Affordable Care Act, California led by establishing the marketplace, Covered California, and the expansion of Medicaid. As a result, at the county level, having established local health initiatives, like My Health LA and Healthy San Francisco, helped streamline enrollment and will continue being critical in advancing the goal of universal coverage. Opportunities for advancements can arise even among adverse developments like the recent federal decision to rescind Deferred Action for Childhood Arrivals (DACA). California has and must remain persistent in its commitment to these young families both by advocating for passage of a federal legislative solution for DACA and ensuring they have health insurance coverage.

Fortunately, California's leadership has committed to move California forward. With legislative efforts for universal coverage and single-payer proposals, California continues to push towards improving health coverage. Earlier this year, the assembly established the Select Committee on Health Care Delivery Systems and Universal Coverage, which will hold ongoing, informational hearings so the committee can develop plans for achieving universal health care in California. The initial information hearings offered an overview of the current state of health coverage and access and highlighted world models of health coverage and payment as we continue our path towards

LESSON #3:

Policy Research, Analysis, and Evaluation Matter

How Did We Get Here?

Child development research highlighting the rewards of investing in children's health played an important role in building support for Health4All Kids. Advocates did not just rely on the fact that covering all children is the right thing to do. Instead, they relied on empirical research that showed that investments in children's health had a tremendous impact on their productivity and health as they became working adults. Data on investments in early childhood, including brain science, was in its early stages when California's campaign for covering all children began. The creation of state and local First 5 commissions—dedicated to promoting healthy childhood development in the first five years of life—came out of this early childhood investment research. And the First 5 funding across the state helped promote and advance such research and investments in early childhood. Today, there is a greater understanding and resonance of childhood health research among policymakers across the political spectrum and among business leaders.

Data revealed a growing number of mixed-immigration-status families in California and a political climate more amenable to supporting programs for all of California's children. In the years leading up to passage of Health4All, survey data not only identified that many citizen children live with immigrant parents but also that the percentage of mixed-status families was growing and now accounts for half of households in California's communities. This information was not only relevant for policymakers but also for communities themselves who became aware that the aggregate trends across the state had started to resemble their own family makeup. In addition, public polling surveys and focus groups were conducted throughout the various stages of California's larger campaign for Health4All. For example, a poll in 2006 found that two out of three voters (66 percent) support a plan to cover every child in California with health insurance after specifically being told that it would include coverage for children of undocumented immigrants. This support was significant across political affiliation, with 79 percent of Democrats, 70 percent of Independents, and 48 percent of Republicans supporting such a plan. Most of this data was directed and shared with policymakers. One interviewer noted that more attention could have been paid to directing such public polling data back to the public and communities themselves as part of the larger advocacy communications.

Policy analysis quantifying the cost of covering the remaining ineligible children—based on county experiences covering a similar population—helped build confidence that statewide coverage was fiscally sound. The multi-tiered evaluation from Santa Clara's CHI/Healthy Kids program provided important data on utilization, take-up, and costs for this new population of covered children. This historical experience provided greater certainty for policymakers considering moving to a statewide program. The evidence available made clear the costs and benefits of covering all children in order to ensure informed decision-making when considering program expansions.

> **"Demonstrating a successful program is its greatest protection."**

Decades of policy evaluation about how to best enroll and keep children in coverage led to wise decisions to automate enrollment and integrate children already enrolled in local programs and limited-scope Medi-Cal into one full-scope Medi-Cal program. Multiple government and philanthropically funded evaluations of enrollment and retention in children's coverage programs paved the way for policy decisions made in California. In line with California's decision to move children from its separate CHIP program into Medi-Cal in 2013, policymakers decided to include Medi-Cal children who were not lawfully present. This avoided the administrative duplication of having to create a new, separate program and reflected the objective of inclusion rather than one of "separate but equal." (Children who are not lawfully present, however, are paid for mostly with state-only funds.)

In addition, the state would also automatically enroll children with limited-scope Medi-Cal into full-scope Medi-Cal on the effective date of the new program. As a result, during the implementation phase before the effective date, stakeholders proactively encouraged families to enroll in limited-scope Medi-Cal so that their children's limited-scope coverage would automatically be converted to full-scope coverage on the effective date. This strategy provided a strong start for Health4All Kids, with more than 100,000 children from pre-existing programs who enrolled in limited-scope receiving full-scope coverage on the first day of implementation.

The Work Ahead

Prioritize monitoring and evaluating the outcomes of covering all children to demonstrate the success of including undocumented children and make the case for the continuation of coverage. The fact that more than 200,000 children either successfully transitioned to the Health4All Kids

program or enrolled for the first time is worth celebrating. However, given potential federal funding challenges for health coverage programs and California's many budgetary needs, in the coming months and years, it will be important to monitor and evaluate the impacts of the program on children's health, readiness to learn in school, and ability to ultimately thrive as productive and healthy adults.

Ensure all children are accessing recommended and needed care. As more children than ever have access to quality, affordable health coverage, equal attention must be paid to ensuring families are knowledgeable about how to use their coverage and that providers in the coverage network are prepared to meet the needs of those enrolled. In the first few years of the Santa Clara County Children's Health Initiative, there were impressive increases in children with a usual source of primary care, as well as access to dental care and vision care.

However, when surveyed, only about half of the children enrolled in Santa Clara Healthy Kids had had a medical visit in the last six months, a rate much closer to the rate of uninsured children than those with private coverage or public coverage, like Medi-Cal.

This evaluation highlights the importance of monitoring children's access to health services to identify any possible gaps in accessing care and find ways to address these gaps. Improving families' knowledge of the health care system, increasing the availability of child-focused providers, and strengthening the quality of child-specific services will help us realize the promise of near-universal coverage for children. The delivery of health care services and promotion of innovative approaches to improve such delivery will be critical to improving the health and well-being of children.

LESSON #4:

Building on All Types of Available Financing—Philanthropic, Private, Local, State, and Federal—is Key

How Did We Get Here?

Strong and sustained philanthropic support. A key asset in the effort to cover all children was the leadership, commitment, and support of grantmakers and other funders who saw the importance of expanding coverage to more Californians. The David and Lucile Packard Foundation (the Packard Foundation) saw the promise in Santa Clara's effort and heavily invested not only in its program but also in replicating its model in other counties and building a critical mass of regional and political support. In addition, the Packard Foundation funded the aforementioned multi-level evaluation of Santa Clara's program in order to demonstrate its statewide application. Other leading health care foundations—such as Blue Shield of California Foundation, the California Health Care Foundation, The California Endowment, The Wellness Foundation, and others—coordinated among themselves to lend strategic support for statewide advocacy coalitions, as well as for furthering local county initiatives, and partnered with local foundations, local health plans, and First 5 commissions to do the same. The foundations worked together to support various aspects of the effort including strategic communications and extensive public education, a sustained investment in the local and state advocacy coalitions, research, direct premium support for local initiatives, and short-term funding for government activities. They remained engaged for the long haul throughout many stages of advocacy and coalition-building and continued investments even after various setbacks.

Local financing instability led to the common goal that a state solution was needed. One of the persistent challenges throughout the campaign was financing local and state coverage programs. While foundations, counties, First 5 commissions, and local health plans stepped up to provide funding for *local* Health Kids program coverage costs, in the long run this financing model was not sustainable and instead was intended to build critical political mass to successfully achieve a sustained statewide coverage program funded by state financing. As time went on, some local children's programs had to either roll back coverage dramatically or close entirely.

> **"We're not going to win if Medi-Cal is starving."**

Child-focused organizations did not have sufficient political clout alone to make state-financed children's coverage a top legislative priority statewide. From the state perspective, as local efforts were reaching critical mass, state policy leaders were initially not willing to provide state funding for children's coverage expansion until 2007, when they embarked on their own large-scale health reform effort. Several policymakers stepped up to champion children's coverage and legislative leadership was interested, but, at the time, the political urgency did not exist to prioritize its funding over other budget interests. In addition, the Children's Coalition did not have sufficient political

clout to move children's coverage as a top legislative/budget priority. After the collapse of California's health reform effort in 2007, legislative leadership wanted to salvage children's coverage from the fall out; however, the economic recession of 2008 made the political climate inhospitable to such an initiative.

The Work Ahead

Prioritize the essential foundations of coverage expansions. Both Medicaid and CHIP are the cornerstones of health care coverage for children in all states. That is certainly the case in California, where more than half of all California children have coverage through Medi-Cal. Since Medi-Cal also houses the SB 75 (Health4All) program, preserving and enhancing both federal programs—by advocating for continued federal CHIP funding with the enhanced match and defending Medicaid from federal cuts and other payment or programmatic changes—remain a major priority for all stakeholders.

Nurture and maintain coalitions to quickly mobilize against funding cuts. According to stakeholders in other states that provide coverage for all children, collective advocacy efforts have played a major role in overcoming threats to program funding. Despite temporary setbacks in some of these states, coalitions have, for the most part, been able to act quickly to defeat efforts to cut funding. Once established, it is far easier to make the case for continuing to provide coverage for children and its demonstrable benefits than it is to cut programs that will result in children's losing coverage.

Identify new opportunities for funding. In addition to the regular sources of health care funding, new resources must be identified and championed not only to expand coverage but to secure timely access to care. In 2016, the Health4All Coalition joined the American Heart Association, the American Lung Association, and others in promoting Proposition 56, a California ballot measure that secured additional funds for Medi-Cal provider payments. Currently, the state's budget assumes that CHIP's enhanced federal match is no longer available. However, as of this writing, the major bipartisan CHIP bills in Congress both propose a continuation, albeit a 5-year phase down, of that enhanced funding. In California, that enhancement match amounts to $500 million in 2018 and 2019. Those funds can go a long way toward securing and improving children's health, particularly immigrant mental health, as well as timely access to dental and mental health care.

LESSON #5:

The Shared Agenda of Health, Anti-poverty, and Immigrant and Civil Rights Leaders is a Stronger Agenda for Children and Families.

How Did We Get Here?

Establishing trust kept partnerships intact through the tough times. As mentioned, the local leaders and their coalitions built an infrastructure that created trust to advance local coverage programs and ultimately achieved statewide reform. It was not just the local community component that made these coalitions so effective but the partners included within them.

Ensuring a diverse and inclusive group of partners strengthened the effort. In the early stages of the campaign, partners included labor, faith-based organizations, health providers, and advocates who believed in the goal. As local initiatives spread to more counties, the United Ways and their business leaders, local chambers of commerce, and local health plans joined the efforts. Local First 5 associations also became important partners. This coalition model was then taken to the statewide level to include state children's advocates, the association of local CHIs, PICO California, United Ways of California, and several local health plans. This infrastructure not only lent political

validity to the cause but the breadth of its assets—from grassroots engagement to policy expertise—rounded out a comprehensive and effective advocacy team.

The campaign evolved to be led by California's leading health access and immigrants' rights groups and grew stronger. In the next stage of the campaign—Health4All—the coalition established a steering committee that was led by Health Access California and the California Immigrant Policy Center. The Health4All coalition had a similarly effective infrastructure combining the grassroots advocacy with policy expertise but also further broadening and engaging immigrant rights groups that represented and included the community directly impacted by policy change. Further, the participation and children's coverage content expertise by California Children's Health Coalition continued. As mentioned, the coalitions at the various stages of the California campaign were supported by committed local and state health care foundations, rendering a strong and sustained advocacy strategy.

Securing buy-in from state leadership furthered opportunity for progress. Progress for coverage for all children was made possible by the commitment of critical leaders in both the state legislature and the administration. As mentioned above, Senator Ricardo Lara was an influential, vocal champion with key relationships that helped propel forward an agenda for immigrant families, and, in so doing, drive an agenda for children's health as well. Coupled with the changing narrative fueled by advocates and critical philanthropic investments, the governor adopted and embraced the Campaign's message after it was reframed as a civil rights issue. One of the most notable reflections of the coalition's work was Governor Brown's mention of "undocumented Californians"—a phrase coined in the campaign that championed immigration and health care—in his January 24, 2017, State of the State address. He said, "Whether it's the threat to our budget, or to undocumented Californians, or to our efforts to combat climate change... this is a time which calls out for courage and for perseverance."

The adoption of the campaign's message and goals by state leaders was necessary to advance policies that address the health needs of all of California's families and communities.

"[As a coalition] we never were discouraged; we had a long- term perspective. It would take the right political landscape."

"The Health4All Coalition—health care advocates coupled with immigrant rights—was the coming together of two existing movements that had their own infrastructures and political momentum and sophistication."

The Work Ahead

Maintain a functioning coalition infrastructure. An all-inclusive coalition that includes children's groups, faith-based groups, organized labor, immigration advocates, the health care industry, the business community, and legislative champions can also sustain a strong coverage program, namely one that is fiscally sustainable and effective at enrolling hard-to-reach children. While not all members must be actively engaged in the day-to-day advocacy, continuing to foster those partnerships with updates and provide them a role in the overall sustaining strategy will prepare the coalition for rapid mobilization should the program face challenges. For example, a sustained and strategic coalition is most effective in advancing coordinated state and local policies, such as mobilizing legislative support or program defense, organizing local events and actions, and shifting the public narrative on inclusive and equitable health care.

Expand and diversify coalition leadership and member organizations to provide a powerful and energizing new perspective on a common goal. It's important to acknowledge the intersection of health with social justice and environmental implications to health. Complementing advocacy efforts will strengthen partnerships and agenda advancement for independent goals. The linchpin to moving Health4All Kids over the finish line was immigrant rights organizations' clarifying the issue of health care as a civil right in a social justice model. Equally important was health care stakeholders' embracing this equity model, underscoring that health is an equity issue.

As mentioned, immigrant integration became part of California's culture and the statement "we are all Californians" includes everyone, regardless of country of birth. As was originally intended, the initial Health4All legislation would have covered the remaining uninsured adults as well as children. The immigrant rights coalition took on the health care cause as the next step of inclusion in coverage after the rollout of the ACA. This came out of a progression of immigrant rights policies, from the Trust Act to driver licenses for undocumented immigrants. Some interviewees speculated that it was this social justice/civil rights framework that inevitably won the support of the governor, who had historically been fiscally conservative on health care issues. While in other states coverage for undocumented immigrants was secured quietly, in California, coverage was won by explicit acknowledgement of our inclusive imperative. As this campaign moves forward for protection of gains and expansion of coverage, framing health for all through this lens will be important.

Rely on demographic trends in California and nationwide to shape coalitions that include children's, health care, and anti-poverty groups, as well as the immigrant and civil rights communities. Children in immigrant families are the fastest-growing component of the U.S. child population, representing 24 percent of all U.S. children. Acknowledging this demographic reality, immigrant rights must be included in all movements to seek justice and civil rights. In the same way that health care became a principle priority of the immigrant rights' agenda, health care advocates should approach immigrant rights as part of our country's health care agenda. Interviewees noted that members of the

health care advocacy community must also advance the cause of immigrant families. Such support must not be limited solely to a specific domain (for instance, health care coverage or education) but expand as well into immigration policies and practices that affect the health and well-being of families in our communities. Reframing children's issues in this manner—for instance, linking experiences such as the detention and deportation of students or their family members to corresponding negative effects on health, mental health, education, or child safety—provide policymakers with a broader context in which to develop sensible, family-friendly policies across any number of areas, including health, public safety, education, and immigration.

LESSON #6:

Value Community Partners to Build Trust and Sustain Future Change

How Did We Get Here?

An individual or family's enrollment in a program often depends on whether a family hears about a program or gets help with the process from someone they know or trust in their community. Working with trusted community partners that already interact with children and families (like schools, faith-based organizations, and immigrant service organizations) is an effective strategy. The importance of this trusting relationship is particularly prominent for immigrant families, whose decision to enroll in a health coverage program hinges on families believing the benefit of enrolling their children outweighs possible risks and uncertainty. These concerns are particularly salient in today's political environment. Even in a generally more inclusive state like California, families face the very real threat of detention, deportation, and the breaking apart of their family. This toxic environment not only affects the newly eligible undocumented immigrant children but citizen and lawfully residing children of immigrant parents. Federal and state law prescribe privacy protections for information provided to health care affordability programs. Yet, the threat of arbitrary detentions and deportations creates a "chilling effect" for families enrolling their children in coverage and may cause parents to consider withdrawing their children who are already enrolled.

> **"In a difficult climate, you only have contact with those you trust."**

Trusted community organizations have been the best messengers for talking to immigrant families about the benefits and risks of public programs. Since the first children's coverage program began in San Mateo in 2001, California Coverage & Health Initiatives (CCHI) has built a strong network of local outreach and enrollment workers who know how to enroll and retain immigrant children who were ineligible for federally funded, full-scope Medi-Cal. This was a key

lesson echoed by local initiatives as well as other states with programs covering undocumented immigrant children. Community health workers, certified enrollment counselors, and *promotoras* are a key ingredient of success, providing a trusted and continued source of information for immigrant families.

The Work Ahead

California must continue to invest in and strengthen its essential community workforce. In a time of particular fear and uncertainty for immigrant families, the value of trusted field partners continually engaging and informing families about policy developments and changes is more critical than ever. The continued investment and integration of direct service partners—like community health workers, certified enrollment counselors, and *promotoras*—will help advocates continue to engage and relay accurate information to enroll, retain, and increase utilization of health coverage, particularly as information about immigrant rights regarding the privacy of health coverage information and immigration enforcement becomes more important. Children Now's community survey found that the "red cards" created by the Immigrant Legal Resource Center were a particularly valuable resource for community workers to provide to families.[65] As families are trying to understand the risks of applying for coverage and whether their information will be shared, having a trusted enrollment assister explain the current law protecting their privacy and its implications can make the difference in whether a child is enrolled or not. Another survey of enrollment assisters indicated that when a trusted community organization explains that the county or state cannot share any information for immigration enforcement purposes, families continue to sign up.[66]

Advocates for health coverage must continue to work closely with low-income immigrant families who are enrolled in Medi-Cal or are in need of care, as they are the most powerful voices for programs like Medi-Cal. Engaging and empowering family members as active advocates themselves not only provides valuable insights into how best to actually serve the community but also offers the most compelling voice to policymakers. Examples of ways that community members can participate include testifying in legislative hearings, mobilizing peers and community members, being the face and voice of program promotion and advocacy via media outlets, and contributing to advocacy strategy and outreach planning efforts. Organizing community events can raise general public visibility of health coverage issues in the community and offer a forum where families are encouraged to share their stories with policymakers. The faces and voices of families behind the facts and figures can have a far more compelling and lasting impact for policymakers as well as the public at large.

Lessons Learned from the Past

At the launch event for Santa Clara's Healthy Kids insurance program, enrollment workers were dressed in green shirts and khaki pants and carried clipboards. Families started to leave the event. Leona Butler, of the Santa Clara Family Health Plan, shared how enrollment workers later learned that families thought that the enrollment assisters were instead agents from Immigration and Customs (ICE). As a result, program officials realized that enrollment events and other communications needed to be planned and delivered by trusted members of the community who know how to engage—and not scare away—their peers.

The Road Ahead

CALIFORNIA HAS MADE multiple concrete steps to support children's health. From leading efforts to implement the Affordable Care Act to securing important program investments for immigrant communities, California's children—half of whom are part of an immigrant family—are direct beneficiaries of the state's commitment to its diverse constituency and an example of the critical importance of state and local action to continue to advance as a nation.

In the wake of the 2016 election, states and localities have responded with action agendas reflective of the needs of their constituents. Prior to the election, states and localities took the lead on issues such as same-sex marriage, raising the minimum wage, reforming the criminal justice system, and combating climate change. This localized leadership continues with the support for sanctuary cities but also efforts to protect health care in an increasingly uncertain environment, with California serving as a leader for the nation.

The path toward coverage for all children serves as an example for the policy victories made possible by a strong and diverse coalition that unites a number of different issues and experiences. As advocates for children, the current political environment behooves us to consider the impact of policy on their health and development. Health care is just one thread in the ongoing national debate about immigration, but it is a crucial one. At stake is the foundation and preservation of effective state and local systems that ensure the health and development of all children, and, in doing so, safeguard a state's ability to face the economic challenges of the future.

As such, advocates for children must also work to prevent federal immigration policy from snuffing out the candle of opportunity that California hopes to create for all children. Unfortunately, immigration status remains a social determinant of health in our country.[67] The effort continues to ensure that older, undocumented siblings and parents of immigrant children also have access to health coverage. However, further work is required to overcome and address the fear and anxiety that many families experience when enrolling a child in health care programs or taking a child to a doctor's appointment or emergency room because it might lead to detention, deportation, or family separation. Advocates must continue work to ensure that California forcefully stands by the California Values Act and advances the evolution it has witnessed in these last few decades.

The morning after the 2016 Presidential election, California Senate President Pro Tempore Kevin de Leon and California Assembly Speaker Anthony Rendon released a simple joint statement. Responding to the concerns raised by the president-elect's campaign, the two state leaders announced their intent to defend California's constituents and the advances the state had made. The statement concluded with the following:

> *"California no era una parte de esta nación cuando comenzó su historia, pero ahora somos claramente los encargados de mantener su futuro."*
>
> *"California was not part of this nation when it began its history, but now we are clearly responsible in maintaining its future."*

Moving forward, issues of health care and immigration will continue to intersect and highlight the fundamental notion that the issues are inseparable for millions of families and therefore, so, too, must we as advocates work together. California's success in funding, implementing, and maintaining quality, affordable coverage for every child, regardless of where they are born, provides a blueprint for other states to use in providing health care coverage for all children. However, even more pertinent, California serves as an example of advancing a broader, inclusive, and progressive agenda at the state level, despite the challenges at the federal level. By prioritizing the needs of its children, California is recognizing the responsibility to invest in the structures that protect and raise all children—strong families, nurturing institutions, and supportive communities. In doing so, we advance solutions in the best interests of our children who are essential to positioning the state and the nation for a prosperous and bright future.

Acknowledgements

Authors

Mayra Alvarez
Kristen Golden-Testa
Aracely Navarro
Ruel Nolledo

Many members of The Children's Partnership team supported the development of this report. Jessica Fernandez and Jackie Rodriguez guided the communications strategy and design process. Sonya Schwartz, consultant to The Children's Partnership, provided strategic input and essential research, content, and editorial assistance.

This report is the result of extensive conversations with leaders of the profiled efforts. The Children's Partnership would like to thank the following organizations and individuals for their thoughtful contributions and ongoing partnership.

Organizations

100% Campaign
Blue Shield of California Foundation
California Coverage & Health Initiatives
The California Endowment
California Health Care Foundation
California Immigrant Policy Center
CaliforniaHealth+Advocates
Children's Defense Fund-California
Children Now
Clinica Monseñor Oscar Romero
The David and Lucile Packard Foundation
Georgetown Center for Children and Families
Health Access
Health Net
Kaiser Permanente
LA Care
PICO California
Redwood Community Health Coalition
Santa Clara Family Health Plan
Santa Clara Valley Health and Hospital System
Stanford University
United Ways of California
University of Southern California
UC Berkeley Center for Labor Research & Education
Working Partnerships, Santa Clara
Yolo County Children's Alliance

Individuals

Bob Brownstein
Alison Buist
Leona Butler
Lawrence Cooper
Judy Darnell
Brenda Diaz
Mark Diel
Betzabel Estudillo
Richard Figueroa
Susan Fleischman
Ana Grande
Kelly Hardy
Howard Kahn
Katie Heidon
Jim Keddy
Deena Lahn
Wendy Lazarus
Eugene Lewitt
Peter Long
Laurel Lucia
Burt Margolin
Marian Mulkey
Mike Odeh
David Panush
Manuel Pastor
Chris Perrone
Robert Phillips
Sherry Novick
Suzie Shupe
Bob Sillen
Michele Stillwell-Parvensky
Catherine Teare
Liane Wong
Anthony Wright

Foundations

The Children's Partnership gratefully acknowledges the generous support received for the development and dissemination of this report from Blue Shield of California Foundation, The California Endowment, and the David and Lucile Packard Foundation.

Endnotes

1 Alisa Chester and Joan Alker, "Medicaid at 50: A Look at the Long-Term Benefits of Childhood Medicaid," Georgetown University Center for Children and Families, July 27, 2015, accessed November 15, 2017, https://ccf.georgetown.edu/2015/07/27/medicaid-50-look-long-term-benefits-childhood-medicaid/.

2 Author's estimate based on the sum of the original figure provided by Joan Alker and Alisa Chester, plus approximately 97,957 children newly enrolled in Medi-Cal through the SB 75 expansion, between May 2016 and November 2017. Alker and Chester, "Children's Health Coverage Rate Now at Historic High of 95 Percent," Georgetown University Center for Children and Families, October 2016, accessed June 6, 2017,_ https://ccf.georgetown.edu/2016/10/26/childrens-health-coverage-rate-now-at-historic-high-of-95-percent/. "SB 75 Transitions and New Enrollees by County: December 4, 2017," Department of Healthcare Services, accessed December 15, 2017 at http://www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/SB75/SB75_Enrollees_County_120417.pdf.

3 California AB 60 (Signed by the governor on October 3, 2013).

4 California SB 1159 (Signed by the governor on September 28, 2014).

5 Healthy SF (website), accessed November 15, 2017, http://healthysanfrancisco.org/. My Health LA (website), https://dhs.lacounty.gov/wps/portal/dhs/coverageoptions/myhealthla.

6 Dowell Myers, Stephen Levy, and John Pitkin, "The Contributions of Immigrants and Their Children to the American Workforce and Jobs of the Future," The Center for American Progress, June 19, 2013, accessed September 9, 2017, https://www.americanprogress.org/issues/immigration/reports/2013/06/19/66891/the-contributions-of-immigrants-and-their-children-to-the-american-workforce-and-jobs-of-the-future/.

7 "Health4AllKids Progress Update: New Community Survey Results," Children Now, April 2017, accessed September 15, 2017, https://www.childrennow.org/files/6714/9374/6391/H4AK-SurveyUPDATE_4_25_17FINAL.pdf.

8 California Department of Health Services, "Healthy Families Program (HFP) and Medi-Cal For Children (MCC) Outreach and Education Campaign: 2000 Report to the Legislature," April 2000, accessed September 15, 2017, http://www.dhcs.ca.gov/dataandstats/reports/Documents/Medi-Cal%20Reports/April%202000%20Outreach%20Plan.pdf.

9 Ibid., 25.

10 Gregory D. Stevens, PhD, MHS, Kyoko Rice, and Michael R. Cousineau, DrPH, "Children's Health Initiatives in California: The Experiences of Local Coalitions Pursuing Universal Coverage for Children," *American Journal of Public Health*, 2007 April; 97(4): 738–743, accessed September 4, 2017, https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1829340/.

11 Peter Long, "A First Glance At The Children's Health Initiative In Santa Clara County, California," Kaiser Commission on Medicaid and The Uninsured, August 2001, https://kaiserfamilyfoundation.files.wordpress.com/2001/07/2260-first-glance-at-the-children_s-health-initiative-in-santa-clara-county-california.pdf.

12 "The Santa Clara County Health Kids Program: Impacts on Children's Mental, Dental, and Vision Care," Mathematica Policy Research, Inc., July 2005, accessed March 1, 2017, https://www.mathematica-mpr.com/-/media/publications/pdfs/santaclara-app.pdf.

13 California Coverage & Health Initiatives (website), "Mission," accessed October 1, 2017, http://cchi4families.org/about/mission.html.

14 "Children's Health Care Programs: Opportunities for Coordinating Application and Enrollment Efforts," California Assembly Health Committee, March 29, 2005, accessed November 27, 2017, http://ahea.assembly.ca.gov/sites/ahea.assembly.ca.gov/files/hearings/March%2029%20Background%20Paper%20Final.pdf.

15 "California Health Care Almanac: Covering Kids: Children's Health Insurance in California," California Healthcare Foundation, November 2012, accessed November 27, 2017, http://www.chcf.org/~/media/MEDIA%20LIBRARY%20Files/PDF/PDF%20C/PDF%20ChildrensHealthCoverage2012.pdf.

16 Steven P. Wallace et al., "Undocumented Immigrants and Health Care Reform: A Final Report To The Commonwealth Fund," UCLA Center for Health Policy Research, August 31, 2012, http://healthpolicy.ucla.edu/publications/Documents/PDF/undocumentedreport-aug2013.pdf.

17 Carolina Coleman, "Children's Health Coverage Under the ACA Part I: Inventory of Children's Health Programs," Insure The Uninsured Project, January 2014, accessed September 4, 2017, http://www.lpfch.org/sites/default/files/field/publications/itup_part_1_childrens_health.pdf.

18 Maureen Finan, "CaliforniaKids Healthcare Foundation: Our History, Our Experience, and Our Future, July 1992 – March 2006," CaliforniaKids Healthcare Foundation, December 2006, accessed November 27, 2017, http://www.californiakids.org/history12-06.pdf.

19 Ian Hill et al., "Growing Pains for the Los Angeles Healthy Kids Program Findings from the Second Evaluation Case Study," First 5 LA & The California Endowment, April 2008, accessed September 4, 2017, http://www.first5la.org/files/HealthyKids_CaseStudy_Wave2.pdf.

20 Coleman. "Children's Health Coverage Under the ACA Part I."

21 California HealthCare Foundation, November 2012, "California Health Care Almanac."

22 "Governor Ignores Significant Coalition Pressure To Save Children's Health Program," Children's Defense Fund, May 14, 2012, accessed August 12, 2017, http://www.cdfca.org/newsroom/press-releases/2012/governor-ignores-significant.html?referrer=https://www.google.com/.

23 "California Counties Expand Children's Health Initiatives," States in Action: Innovations in State Health Policy, July 5, 2006, accessed August 12, 2017, http://www.commonwealthfund.org/publications/newsletters/states-in-action/2006/jul/july-2006/updates--new-developments-in-ongoing-programs/california-counties-expand-childrens-health-initiatives.

24 Steve Lawrence, "Governor chided for vetoing bills on children's health care," *Monterey County Herald*, October 9, 2005, accessed August 12, 2017, https://www.piconetwork.org/news-media/coverage/image/0040.pdf.

25 "Healthy Kids Funds Removed From Budget," California Healthline, June 26, 2006, accessed November 19, 2017, https://californiahealthline.org/morning-breakout/healthy-kids-funds-removed-from-budget/.

26 "California Proposition 86, Cigarette Taxes," Ballotpedia, accessed August 12, 2017, https://ballotpedia.org/California_Proposition_86,_Cigarette_Taxes_(2006).

27 "Governor's Healthcare Proposal," Commonwealth Fund, accessed October 17, 2017.

28 Ian Hill and Sarah Benatar, "What Are the Implications of Losing Healthy Kids?," Prepared for First 5 LA, Urban Institute, October 2009, accessed November 15, 2017, https://www.urban.org/sites/default/files/publication/28921/412164-What-are-the-Implications-of-Losing-Healthy-Kids-.PDF.

29 Ibid.

30 Scott Graves, "State Freezes Enrollment in Healthy Families Program," California Budget & Policy Center, June 30, 2009, accessed November 19, 2017, http://calbudgetcenter.org/blog/state-freezes-enrollment-in-healthy-families-program/.

31 "Medi-Cal Statistical Brief: Medi-Cal's Historic Period of Growth," Research and Analytical Studies Division, California Department of Health Care Services, accessed August 12, 2017, http://www.dhcs.ca.gov/dataandstats/statistics/Documents/New_24_Month_Examination.pdf.

32 "Two More Years: What Does Continued CHIP Funding Mean For California?" California Healthcare Foundation, May 2015, accessed August 12, 2017, http://www.chcf.org/~/media/MEDIA%20LIBRARY%20Files/PDF/PDF%20T/PDF%20TwoYearsCHIPFunding.pdf.

33 Joan Alker, Tara Mancini, and Martha Heberlein, "Uninsured Children 2009-2011: Charting the Nation's Progress," Georgetown University Center for Children and Families, October 2012, accessed November 15, 2017, https://ccf.georgetown.edu/wp-content/uploads/2012/10/Uninsured-Children-2009-2011.pdf; Joan Alker and Alisa Chester, "Children's Health Insurance Rates in 2014: ACA Results in Significant Improvements," October 2015, accessed November 15, 2017, https://ccf.georgetown.edu/wp-content/uploads/2015/10/ACS-report-2015.pdf.

34 Alker and Chester, "Children's Health Insurance Rates in 2014." https://ccf.georgetown.edu/wp-content/uploads/2015/10/ACS-report-2015.pdf.

35 "The California Health Care Landscape," Henry J. Kaiser Family Foundation, August 26, 2015, accessed August 12, 2017, https://www.kff.org/health-reform/fact-sheet/the-california-health-care-landscape/.

36 Shannon McConville et al., "Health Coverage and Care for Undocumented Immigrants," Public Policy

Institute of California, November 2015, accessed September 1, 2017, http://www.ppic.org/content/pubs/report/R_1115SMR.pdf.

37 "Legislative Fact Sheet: SB 1005 (Lara) Health For All," Office of Senator Ricardo Lara (website), December 2013, accessed August 12, 2017, http://diringerassociates.com/wp-content/uploads/2013/12/SB-1005-Fact-Sheet-Health4All.pdf.

38 "Governor Signs Lara's Health for All Kids Act," Senator Ricardo Lara (website), October 9, 2015, accessed August 12, 2017, http://sd33.senate.ca.gov/news/2015-10-09-governor-signs-lara%E2%80%99s-health-all-kids-act.

39 "SB 75 Full Scope Medi-Cal for All Children Eligibility and Enrollment Plan," California Department of Health Care Services, November 8, 2017, accessed November 27, 2017, http://www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/SB75/SB75_Enrollees_County_110817.pdf.

40 "CalSIM version 1.91 Statewide Data Book 2015–2019," UCLA Center For Health Policy Research, May 2014, accessed August 12, 2017, http://healthpolicy.ucla.edu/publications/Documents/PDF/2014/calsimdatabook-may2014.pdf.

41 California Department of Health Care Services, "SB 75: Transitions and New Enrollees by County, November 8, 2017," accessed November 27, 2017, http://www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/SB75/SB75_Enrollees_County_110817.pdf.

42 Joan Alker and Alisa Chester, "Children's Health Coverage Rate Now at Historic High of 95 Percent," Georgetown University Center for Children and Families, October 2016, accessed June 6, 2017, http://ccf.georgetown.edu/wp-content/uploads/2016/11/Kids-ACS-update-11-02-1.pdf.

43 "The Affordable Care Act and Children's Coverage in California: Our Progress and Our Future," The Children's Partnership, accessed November 1, 2017, http://www.childrenspartnership.org/wp-content/uploads/2016/06/TCP__Children_and_the_ACA_Report_2016_1.pdf.

44 Marta Tienda and Ron Haskins, "Immigrant Children: Introducing the Issue," The Future of Children, Spring 2011, accessed November 27, 2017, https://ncfy.acf.hhs.gov/sites/default/files/docs/20064-Immigrant_Children-Introducing.pdf.

45 "One-Fourth of Kids in Immigrant Families Are Living in Poverty," *Casey Connects* (blog), February 2, 2017, accessed November 27, 2017, http://www.aecf.org/blog/one-fourth-of-kids-in-immigrant-families-are-living-in-poverty/.

46 Tyler Woods and Devlin Hanson, "Demographic Trends of Children of Immigrants," Urban Institute, October 2016, accessed November 27, 2017, https://www.urban.org/sites/default/files/publication/85071/2000971-demographic-trends-of-children-of-immigrants_2.pdf.

47 49.1 percent of children in California in 2014 lived with one or more foreign-born parent, and there was a total of 9,118,201 children living in California that same year, or 4,477,037 children. Based on "Children Living with One or More Foreign-Born Parent by Assembly District" (2010-2014), and Child Population by County (2016), Kidsdata.org, a Program of Lucile Packard Foundation for Children's Health, accessed March 12, 2017, http://www.kidsdata.org.

48 "Resilience in an Age of Inequality, Immigrant Contributions to California," California Immigrant Policy Center, 2014. Data from the 2010-2014 American Community Survey.

49 In 2014, Latinos surpassed whites as the largest racial/ethnic group in California. As of July 1, 2014, there were about 14.99 million Latinos in California, and only 14.92 million non-Hispanic whites in the state. Javier Panzar, "It's official: Latinos now outnumber whites in California," *Los Angeles Times*, July 8, 2015.

50 Migration Policy Institute (MPI) tabulation of data from US Census Bureau, 2015 American Community Survey (ACS), and 1990 Decennial Census; 1990 data were accessed from Steven Ruggles, J. Trent Alexander, Katie Genadek, Ronald Goeken, Matthew B. Schroeder, and Matthew Sobek, Integrated Public Use Microdata Series: Version 5.0 [Machine-readable database] (Minneapolis: University of Minnesota, 2010).

51 "Summary: Hispanic/Latino Children," Kidsdata.org, a Program of Lucile Packard Foundation for Children's Health, accessed November 16, 2017, http://www.kidsdata.org.

52 Javier Panzar, "It's official: Latinos now outnumber whites in California," *Los Angeles Times*, July 8, 2015, http://www.latimes.com/local/california/la-me-census-latinos-20150708-story.html.

53 53 percent of those arriving in California between 2011 and 2015 came from Asia. Joseph Hayes, "Immigrants in California," Public Policy Institute of California, January 2017, accessed November 27, 2017, http://www.ppic.org/publication/immigrants-in-california/.

54 Jennifer Medina, "New Suburban Dream Born of Asia and Southern California," *New York Times*, April 28, 2013, accessed November 27, 2017, http://www.nytimes.com/2013/04/29/us/asians-now-largest-immigrant-group-in-southern-california.html.

55 Miki Kittilson and Katherine Tate, "Political Parties, Minorities and Elected Office: Comparing Opportunities for Inclusion in the US and Britain," University of California Irvine, March 2004, accessed October 11, 2017, https://escholarship.org/content/qt9j40k1m0/qt9j40k1m0.pdf.

56 Latinos grew from 22 percent of California's working-age population in 1990 to 29 percent in 2006 and are projected to grow to 40 percent by 2020. Deborah Reed, "California's Future Workforce. Will There Be Enough College Graduates?" Public Policy Institute of California, December 2008, accessed March 1, 2017, http://www.ppic.org/publication/californias-future-workforce-will-there-be-enough-college-graduates/.

57 Caitlin Dickerson and Jennifer Medina, "California Farmers Backed Trump, but Now Fear Losing Field Workers," *New York Times*, February 9, 2017, accessed September 1, 2017, https://www.nytimes.com/2017/02/09/us/california-farmers-backed-trump-but-now-fear-losing-field-workers.html.

58 Valerie Hamilton, "California's undocumented workers help the economy grow – but may pay the cost," Public Radio International, March 6, 2017, accessed September 1, 2017, https://www.pri.org/stories/2017-03-06/californias-undocumented-workers-help-grow-economy-theres-cost.

59 Emily Badger, "Immigrant Shock: Can California Predict the Nation's Future?" *New York Times*, February 1, 2017, accessed October 15, 2017, https://www.nytimes.com/2017/02/01/upshot/strife-over-immigrants-can-california-foretell-nations-future.html?mcubz=3.

60 Jennifer Medina, "California Eases Tone as Latinos Make Gains," *New York Times*, February 16, 2013, accessed September 1, 2017, http://www.nytimes.com/2013/02/17/us/california-eases-its-tone-as-latinos-make-gains.html.

61 Gustavo Lopez and Kristen Bialik, "Key findings about US immigrants," Fact Tank, Pew Research Center, May 3, 2017, accessed October 12, 2017. http://www.pewresearch.org/fact-tank/2017/05/03/key-findings-about-u-s-immigrants/.

62 D'Vera Cohhn and Andrea Caumont, "10 demographic trends that are shaping the U.S. and the world," Fact Tank, Pew Research Center, March 31, 2016, accessed November 27, 2017, http://www.pewresearch.org/fact-tank/2016/03/31/10-demographic-trends-that-are-shaping-the-u-s-and-the-world/.

63 "The Changing U.S. Workforce: The Growing Hispanic Demographic and the Workplace," Society for Human Resource Management and the Congressional Hispanic Caucus Institute, September 2016, accessed November 27, 2017, https://www.shrm.org/hr-today/public-policy/hr-public-policy-issues/Documents/15-0746%20CHCI_Research_Report_FNL.pdf .

64 Jeffrey S. Passel and D'Vera Cohhn, "U.S. Population Projections: 2005-2050," Pew Research Center, February 11, 2008, accessed November 27, 2017, http://www.pewhispanic.org/2008/02/11/us-population-projections-2005-2050/. Francine Blau, et al., "The Economic and Fiscal Consequences of Immigration," The National Academies Press, September 2016, accessed March 14, 2017, http://www.nap.edu/23550.

65 "Health4AllKids Progress Update: New Community Survey Results," Children Now, accessed March 1, 2017, https://www.childrennow.org/files/6714/9374/6391/H4AK-SurveyUPDATE_4_25_17FINAL.pdf.

66 Survey conducted by CCHI in April 2017, on file with authors. Questions included the following:

1) Have individuals raised concerns about enrolling, using their benefits, and/or accessing care due to immigration/political climate?

2) Are people asking to be "disenrolled" or "not signed up" for Medi-Cal or other government services due to immigration concerns?

3) Does it happen often or is relatively few and far between?

67 In other words, immigration status is an identity around which barriers are often created that limit the ability to live a healthy and dignified life. See "Immigration Status as a Social Determinant of Health," Consumer Health Foundation and La Clinica del Pueblo, 2016, accessed November 7, 2017, http://www.consumerhealthfdn.org/wp-content/uploads/2016/11/Focus-on-Health.pdf.

www.childrenspartnership.org
@kidspartnership fb.com/kidspartnership