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Toward a Healthy California

Why Improving Access to Medical Insurance for Unauthorized Immigrants Matters For the Golden State

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EXECUTIVE SUMMARY

The Affordable Care Act (ACA, or "Obamacare") has had dramatic impacts on reducing the numbers of uninsured Americans. However, it explicitly left out one important segment of the population with a noticeable lack of access to health insurance and medical care: unauthorized immigrants. While the politics of that decision were understandable, the consequences are problematic in states like California where an important share of the population (roughly seven percent) is undocumented and where an even larger share of children (nearly a fifth) have at least one undocumented parent.

Insurance matters, although the connection to health is sometimes tenuous and unclear. Still, most Americans would rather be with than without – and one clear connection that does promote individual well-being is the way in which medical insurance helps to reduce financial risk and stress. The benefits also seem to accrue beyond the individual: there are broad public health benefits to having more people covered and the current undocumented population, which is often younger and healthier, could actually help improve risk in insurance pools.

While this makes access to health insurance an important issue for everyone in California, it is particularly important to a series of fourteen communities being supported by The California Endowment (TCE) under its "Building Healthy Communities" (BHC) program. These areas – ranging from Santa Ana to South Sacramento, from South L.A. to West Fresno, from City Heights in San Diego to Richmond in the Bay Area – have significant undocumented populations that report very low rates of insurance coverage.

When insurance is spotty, communities are forced to rely on a patchwork of county-level services aimed at providing indigent care as well as various philanthropic efforts seeking to expand the safety net. Some cities and counties in California do better than others at this and the resulting unevenness can be challenging for immigrant families. Fortunately, the state seems to be recognizing that it needs to do better: recently passed legislation provides access to Medi-Cal for undocumented children in the state. This is creating a template for expansion to adults as well for potentially creating opportunities to buy health insurance in a market akin to that created by the state's insurance exchange, Covered California.

Photo by Direct Relief

Research suggests that expanding access to medical insurance could be a gain for the future of the state. But getting there requires not just facts but vision, values, and strategies. The fourteen BHC communities are working with others in a campaign called "Health4All" to try to build public will and remedy the gaps. We suggest that the Golden State's decision makers would do well to listen to their arguments: since mass deportation is unlikely and comprehensive immigration reform seems inevitable (even if distant), the real choice facing the state is whether or not we provide the right policies and programs for a healthy California.

Introduction

While the Patient Protection and Affordable Care Act (ACA, or "Obamacare") has been the subject of heated political debate, it is surely one of the most significant innovations in health policy since Medicare and Medicaid. The ACA has many parts, including efforts to control costs and improve service delivery, but the aspect that has attracted the most attention has been the expansion of health insurance through a combination of the following measures: requiring that health insurers provide coverage to anyone who applies, regardless of preexisting conditions; requiring that family insurance cover children up to age 26; enhancing incentives for employers to provide insurance; the development of new health exchanges (including subsidies for low to moderate income individuals and families who purchase insurance on those exchanges); and the expansion of Medicaid (which the Supreme Court ruled was at the discretion of each state).[1]

Overall, it is estimated that the ACA will eventually expand access to medical insurance to approximately 25 million additional non-elderly uninsured Americans, and that new coverage has already reduced the amount spent on formerly uncompensated care in hospitals by over 20 percent (Buettgens & Carroll, 2012; Kaiser Family Foundation, 2013b).[2] A recent report from the Centers for Disease Control and Prevention suggest that there were already 16 million fewer Americans uninsured in early 2015 compared to early 2013 and the uninsured rate had fallen below ten percent for the first time in fifty years of surveys on the issue (Diamond, 2015). While this, along with the other elements of the emerging system, holds out the promise of a more accessible health care system, there is one demographic group that has been deliberately left out of ACA: undocumented or unauthorized immigrants (Marrow & Joseph, 2015).[3]

That is, of course, a large number of people to exclude: the best estimates suggest that there are between 11 and 12 million unauthorized immigrants residing in the United States, with an estimated 2.5 to 3 million unauthorized immigrants, living in California alone (Hoefer, Rytina, & Baker, 2012; Hoefer, Rytina, & Campbell, 2011; Passel & Cohn, 2011; Passel, Cohn, & Barrera, 2013; Warren & Warren, 2013).[4] Perhaps most relevant here is that unauthorized immigrants have been estimated to represent about 17 percent (or one in six) of all uninsured Americans and, on average, use subsidized medical care and other forms of public assistance less than U.S.-born citizens (Gusmano, 2012b; Ku, 2009; Marcelli, 2004b; Marcelli & Heer, 1998; Passel & Cohn, 2009; Stimpson, Wilson, & Su, 2013; Wallace, Torres, Nobari, & Pourat, 2013b).

While there are surely important questions about whether and how the ACA would benefit unauthorized immigrants and the communities in which they live, there may be a broader concern at hand: research suggests a positive relationship between extending coverage to all uninsured residents (regardless of legal status) and the health and well-being of everyone (Institute of Medicine, 2009; Pauly & Pagán, 2007; Timmermans, Orrico, & Smith, 2014). Inclusion of this population – which is generally younger and

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[1] As of mid-2015, 31 states have expanded their Medicaid programs and the rest have not, although several additional states are actively considering expansion (Kaiser Family Foundation, 2015).

[2] See also (Congressional Budget Office, 2014) on the improvement in insurance and (ASPE, 2015) on the reduction in uncompensated care.

[3] We define "immigrant" as any foreign-born resident of the United States and use both "unauthorized" and "undocumented" to describe those who do not have legal permission to reside in the county (others refer to those in this group as illegal or irregular).

[4] The highest estimate comes from the Migration Policy Institute and utilizes a pooled version (2009-2013) of the American Community Survey (Migration Policy Institute, 2014).

healthier – could also improve the risk pools being created under the ACA. It can also better secure the health of a large share of our workforce – and to the extent that comprehensive immigration reform is a matter of when rather than if – extending coverage will help insure that it is a healthier population that will, at some point, be brought out of the shadows.

This is a national issue that should be addressed by the federal government, both in terms of immigration reform and the expansion of medical insurance. But in the absence of federal action, California is taking both the existing research and the needs of its residents to heart. For example, California has been one of only two states that permit unauthorized immigrants brought to the U.S. as children and who meet five other "Deferred Action for Childhood Arrival" (DACA) criteria to sign up for Medi-Cal (California Pan-Ethnic Health Network, 2013). In 2015, the state passed legislation for a $40 million expansion of Medi-Cal (California's Medicaid program) to cover all undocumented children starting in 2016. While this is progress, it is a scaled back version of the original proposal to cover all California residents that health, immigrant, and equity advocates (as well as their legislative allies) have been working on for several years. And there is also some momentum at the local level: while undocumented adults in the state had remained uncovered unless they happened to live in one of the 11 counties (of 58, in total) that offered services beyond emergency care, an additional 37 counties decided in 2015 to start providing low-cost care to undocumented Californians (Karlamangla, 2015) and every county Welfare Department in California now has a liaison for immigrants of any status (#healthforall, 2015).

While the efforts of the Golden State to provide some insurance security is now attracting the interest of other states (as well as Democratic candidates in their mid-October debate), there is still a gap to close in eligibility, not to mention enrollment and use. In this report, we explain why we need to close those gaps in eligibility, enrollment and use for every resident of California. We start by reviewing why access to health insurance is important for the health of both immigrants and the broader population. We then turn to estimates of the undocumented population in California, including estimates of access to health insurance. Unlike other analysts that seem to assume that unauthorized immigrants lack access to all public programs (Warren, 2014), we instead make use of estimating techniques to identify the unauthorized and then investigate their characteristics, including the use of different sorts of health insurance they may have (e.g. employer-provided versus government-provided). We also discuss what research tells us about how the unauthorized currently access health care (and not just insurance) and use both this and the earlier analysis to consider the policy implications at both the state and local levels.

While we will address issues facing unauthorized residents in the state of California in general, we will be paying special attention to a series of areas that have been part of the "Building Healthy Communities" (BHC) effort launched by The California Endowment (TCE), the largest health foundation in the state. Complementing an effort funded by the Robert Wood Johnson Foundation to develop the field of "social epidemiology," the BHC program is working to improve the "social determinants of health" – of which medical insurance is one – at fourteen sites across the state over a ten-year period.[5] The program involves investments in community capacity to address policy and service delivery in locations ranging from City Heights (in San Diego) to West Fresno, from East Oakland to Del Norte, from Santa Ana to Salinas (a map of the sites is provided in part II of this report).

[5] For more on "social epidemiology," see Berkman & Kawachi (2000); Kawachi & Berkman (2003); Kawachi, Subramanian, & Kim (2008); Marmot & Wilkinson (1999; 2006). For more on the BHC strategy see Pastor, Ito, & Perez (2014).

While there are many differences between these locales, our estimates suggest that they have about twice the share of undocumented residents compared to the state, on average (17 and seven percent, respectively), and thus face exactly the sort of health insurance and health care access issues we discuss.

Indeed, this report was commissioned by TCE to help those BHC sites understand the broader issues at the intersection of health insurance and immigration, identify their own local challenges and opportunities, and develop a broader framework and approach to link with others across the state to address the immigrant coverage gaps that were built into the ACA – as well as to more broadly expand access to and use of health care. But while this report is specifically aimed at education and capacity-building for TCE grantees, particularly those in the BHC sites, we hope that it will be useful to a broader audience and that it can act as a primer for everyone trying to better grasp the issues surrounding medical insurance and undocumented immigrants and why this connection is important for all Californians.

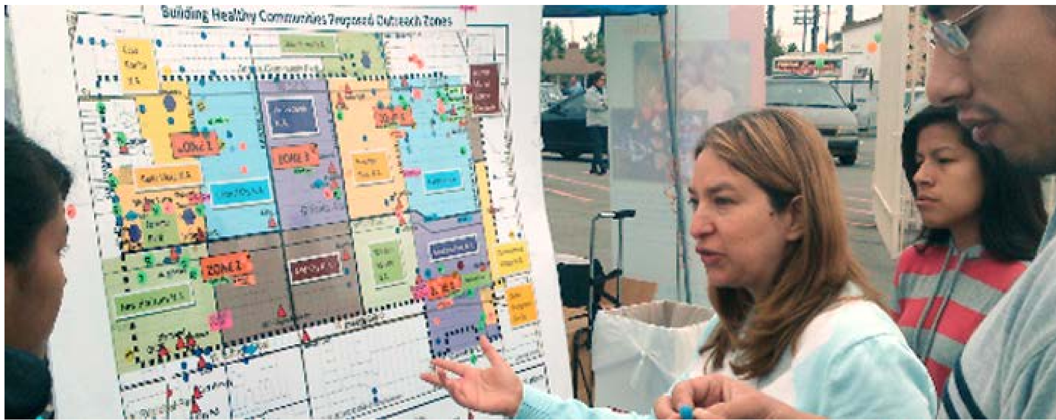

Photo by BHC Connect

I. WHY HEALTH INSURANCE MATTERS

For anyone who has health insurance – and values the security and peace of mind that it brings – the debate about whether it actually improves health might go against common sense. Few middle-class Americans who have either jobs that provide insurance or sufficient income to purchase a private plan would want to be separated from coverage – and, of course, the very logic behind expanding insurance access under ACA assumes that there is a benefit to doing so.[6]

Still, there are important questions about the impact of medical insurance on health and addressing these is an important first step toward understanding whether it matters when medical insurance systems leave undocumented immigrants out of the picture.

We start, however, by sketching out how the recent health care reform managed to leave out undocumented immigrants in California and elsewhere, then turn to the data on the rates of insurance for the unauthorized, and close by discussing why this gap impacts not just immigrants but the whole state.

Photo by KRC LA

THE AFFORDABLE CARE ACT AND UNAUTHORIZED IMMIGRANT ACCESS TO MEDICAL INSURANCE

While authorized U.S. residents and citizens are able to obtain medical insurance through the Affordable Care Act's insurance exchanges or gain access through the Medicaid expansion in expansion states, an estimated 11 to 12 million unauthorized U.S. immigrants are excluded. Specifically, unauthorized immigrants are ineligible for federal funding for: (1) subsidies to make private health insurance more affordable, (2) Medicaid (except for emergency), and Children's Health Insurance Program (CHIP) expansion (except for prenatal care if a state decides to participate), and (3) the Basic Health Program (BHP), which is designed to bridge Medicaid and subsidized private insurance as an alternative to the exchanges for certain lower-income people (Cassidy, 2014; Ku, 2013). Although there are relatively few elder unauthorized immigrants, they also remain ineligible for Medicare (Ku, 2013). Even undocumented immigrant youth with provisional status under DACA are excluded from federal funding for all of these programs (National Immigration Law Center, 2013).

Although California was one of three states in the country with the highest insurance sign-up rates in the ACA's first open enrollment season (Levey, 2014b), an analysis by the UCLA Center for Health Policy Research and the UC Berkeley Center for Labor Research and Education using the California Simulation of Markets (CalSIM) model projected that approximately 1.4 to 1.6 million Californians would remain uninsured in 2015 because of their immigration status (UCLA Center for Health Policy Research & UC Berkeley Center for Labor

[6] There is some past evidence that workers may choose to essentially trade off insurance in return for higher pay, a pattern that suggests either some questions about the relative benefits of coverage or liquidity constraints for lower-income workers. Of course, this sort of choice will not be as available under the mandates in the ACA.

Research and Education, 2014).[7] Projections for after the ACA has been fully implemented in 2019, estimate that some 1.4 to 1.5 million of the 2.7 to 3.4 million Californians who are likely to remain uninsured will be in that condition mostly because of their immigration status. Those numbers do not account for the recent legislation that will provide Medi-Cal to undocumented children, but that is estimated to decrease the number of uninsured by only 170,000 (Taxin & Lin, 2015).

Unauthorized immigrants are not completely left in the cold.[8] First, they will continue to be eligible for emergency Medicaid, prenatal, and some preventive care; and in those states which choose to adopt the new and higher Medicaid percent-of-the-poverty-level thresholds and participate in the CHIP matching program, more U.S.-born children of unauthorized immigrants will qualify for medical insurance. Second, although the threat of losing funding is constant (O'Donnell & McElhaney, 2014), the ACA increased direct funding to Federally Qualified Health Centers (FQHCs) by $11 billion between 2011 and 2015 (Center for Healthcare Research & Transformation, 2013; U.S. Department of Health and Human Services, 2014b). FQHCs serve more than 20 million people in underserved communities (Kaiser Family Foundation, 2011), including 900,000 seasonal migrant workers who rely on designated migrant health centers (U.S. Department of Health and Human Services, 2014a).[9]

While the increased five-year funding for FQHCs – which was recently extended two more years – is substantial, the ACA calls for disproportionate share hospital (DSH) funding to be cut in half from $20 billion to $10 billion by FY 2020 (Kaiser Family Foundation, 2013c; The California Endowment). DSHs or "safety-net hospitals" help cover care for the uninsured and many states use this as a mechanism to reimburse uncompensated care to unauthorized migrants (Martin & Burke, 2010). This reduction in federal funding for DSHs may prove to be detrimental for uninsured immigrants (Neuhausen et al., 2014).

In terms of existing statewide programs to provide medical insurance to unauthorized immigrants, California is one of a small number of states that has provided state-funded coverage for a limited set of medical services regardless of immigration status – although programs are restricted to specific groups such as children or pregnant women (Stephens & Artiga, 2013). For example, CHIP and prenatal care is available to pregnant women regardless of immigration status (National Immigration Law Center, 2014). Legal immigrants have also traditionally been ineligible for Medicaid during their first five years in the U.S., but in California, legally residing immigrants are eligible for state-funded Medi-Cal (Barrios, 2013). Although undocumented immigrants have traditionally not been eligible for full-scope Medi-Cal (something changing as we discuss below), in 2016, unauthorized immigrants under the age of 19 will be eligible for state-funded full scope Medi-Cal benefits (more on this below).

There have also been two unique state-level policy developments in California worth highlighting. First, although the young people residing in California who have achieved deferred action under DACA remain ineligible for federal funding to purchase subsidized insurance through Covered California, the state provided funding to extend Medi-Cal benefits for those with temporary protected status (California Pan-Ethnic Health Network, 2013).[10] It was anticipated that this would set a precedent for covering other individuals, such as the undocumented parents of U.S. citizen children, who were slated to be the

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[7] Data available at (UCLA Center for Health Policy Research & UC Berkeley Center for Labor Research and Education, 2014).

[8] This overview has benefitted from several phone conversations and email exchanges with Leighton Ku of George Washington University.

[9] Also, unauthorized immigrants will not be penalized through the individual mandate provision for not having obtained insurance.

[10] Having taken effect as of January 1, 2014. See (CIPC, 2014).

beneficiaries of executive actions on immigration announced by President Obama in November 2014 – but this has been put on hold as the executive actions have been held up by a federal judge in Texas (Markon, 2015).

Second, California has also seen the development of efforts aimed at extending health insurance to all undocumented residents. In 2015, state senator Ricardo Lara (D-Bell Gardens) reintroduced a bill that he had proposed the prior year. Co-authored with several other senators and assemblymen, SB 4 (or "#Health4All") sought to allocate state funds to expand full Medi-Cal eligibility to include undocumented residents of the state. It also directed the state to request a federal waiver to allow undocumented immigrants to shop in the state's insurance exchange for private coverage without any subsidies (Brindis et al., 2014; Health Access, 2015a; Karlamangla, 2014b; Lara et al., 2014; Medina & Goodnough, 2014; Seipel, 2015; California Legislative Information, 2015). In June of that same year, the state government passed a scaled down version of this bill that covers all unauthorized children (Wright & Health Access, 2015). While there is still quite a gap to close, this is a significant first step.

There are also local efforts to provide unauthorized immigrants with insurance and care as California state law requires counties to provide health care for low-income residents who are uninsured but do not qualify for Medi-Cal or other federal or state programs. Counties generally vary in their interpretation of which residents and what type of care they are obligated to cover and the infrastructure they use to deliver services to the medically indigent (Health Access, 2015b). As the ACA implementation continues across the state, even this patchwork of safety net care for undocumented immigrants is endangered due to shifts in healthcare funding priorities, a topic we take up later in this report.

Unauthorized Immigrants, Medical Insurance, and Health Care

Of course, failing to include the unauthorized in this new expansion of subsidized health insurance would not be problematic if they were already largely covered – but they are not. Representative national data that include immigrant legal status, insurance coverage, medical care use, and other variables important for studying coverage and care are not readily available. Existing research, however, intimates that between one-half to more than two-thirds of unauthorized U.S. immigrants have been uninsured since such estimates began being made in the late 1990s (Brown, Ojeda, Wyn, & Levan, 2000; Brown, Wyn, Yu, Valenzuela, & Dong, 1998; Marcelli, 2004b; Marcelli & Heer, 1998; Wallace, Torres, et al., 2013b). One recent study that is nationally representative suggests a statistically similar percentage toward the higher end: applying legal status predictors obtained from the 2008 Survey of Income Program Participation (SIPP) data to 2011 American Community Survey (ACS) data, Capps et al. report that 71 percent of all adult unauthorized immigrants were uninsured nationally (Capps, Bachmeier, Fix, & Van Hook, 2013).

In California, an early study representative of Mexican immigrants (Marcelli & Heer, 1998), for example, applied predictors of unauthorized legal status to foreign-born Mexican adults enumerated in the 1994-1995 Current Population Survey (CPS) data and found that the same proportion of unauthorized Mexican immigrants and U.S. citizens residing in Los Angeles County (13 percent) relied on Medi-Cal, and that other immigrants were slightly more likely to have done so (15 percent). A follow-up study applied legal status predictors to foreign-born Latinos in the 1995-1997 and 1999-2001 March CPS data and 1996-1998 and 2000-2002 February CPS data and found that approximately two-thirds of all non-elderly unauthorized Latino immigrant adults were uninsured in California (Marcelli, 2004b). The same study also found that although the proportion of unauthorized Latino immigrants

who were eligible for employer-sponsored health insurance was slightly lower than the state average, unauthorized Latinos were significantly more likely to embrace ("take-up") this offer.

Other studies which have employed random household sample data to estimate unauthorized immigrant insurance coverage report a wider range of estimates. UCLA researchers (Brown et al., 2000), for instance, found that 74 percent of all unauthorized U.S. Mexican immigrants were uninsured and that only 23 percent were offered coverage from an employer in California. Another UCLA study, which analyzed 2001 California Health Interview Survey (CHIS) data, found that more than half of non-citizens in California without a green card (most of whom were assumed to be unauthorized migrants) were uninsured (Brown, Ponce, Rice, & Lavarreda, 2002). Looking forward, a study by the UCLA Center for Health Policy Research and the UC Berkeley Center for Labor Research and Education used the California Simulation of Insurance Markets (CalSIM) model to make post-ACA projections. They found that by 2019 up to half of the remaining 2.7 to 3.4 million uninsured Californians, will be undocumented (Lucia, Dietz, Jacobs, Chen, & Kominski, 2015). The researchers also project that of the remaining uninsured, nearly three-quarters will be Latino.

Studies employing different data also confirm that unauthorized immigrants have the highest rates of being uninsured. Employing 2000-2001 Los Angeles Family and Neighborhood (LAFANS) data, for example, RAND researchers estimated that about two-thirds of unauthorized immigrants residing in Los Angeles County were uninsured (Goldman, Smith, & Sood, 2005). However, data from a 2006 random household telephone survey in Orange County and from 2009 CHIS data for all of California suggest that about 50 percent of all unauthorized Latinos lacked coverage (Bustamante et al., 2012; L. R. Chavez, 2012; Wallace, Torres, et al., 2013b). Finally, a more recent application of legal status predictors from Enrico A. Marcelli's Los Angeles County Mexican Immigrant Health & Legal Status Surveys (LAC-MIHLSS II) to 2009-2011 ACS data found that 61 percent of the working age (25-64 years old) undocumented Californians lacked insurance (Pastor & Marcelli, 2013).

In the following pages, we describe a new approach, one based on techniques explained and developed in (Capps et al., 2013; Hook, Bachmeier, & Harel, 2015), to estimate both the size of the undocumented population as well as the key characteristics of that population, including the rate and type of medical insurance. Suffice it to say here that, taken together, these studies suggest that roughly half to slightly more than two-thirds of unauthorized immigrants in California lack medical insurance (our own figures below remain at around 60 percent uninsured for working age unauthorized immigrants) and the current configuration of the ACA is not aimed at improving this situation.

Does Medical Insurance Improve Health and Well-Being?

Although health researchers generally agree that expanded insurance coverage increases the use and quality of medical care (Institute of Medicine, 2009; Pauly & Pagán, 2007), the notion that expanded public health insurance coverage itself improves health outcomes has actually been questioned (Douthat, 2013). For example, a RAND study of Medi-Cal (California's Medicaid program) conducted during the 1970s and recent evidence from Oregon's 2008 Medicaid expansion (Baicker et al., 2013; Lurie, Ward, Shapiro, & Brook, 1984) suggest that increased access to medical insurance – while protecting lower-income populations from financial and mental distress – may have little short-term effect on the "actual causes" (such as poor diet and smoking) as contrasted with the "leading" causes (such as heart disease and cancer) of long-term health and mortality (Buxton & Marcelli, 2010; McGinnis & Foege, 1993).

The Oregon study has become particularly influential in recent public debates. It suggests that while increased access to Medicaid is positively associated with a diagnosis of diabetes and self-reported health and negatively associated with a diagnosis of depression, there was no association with risky levels of glycated hemoglobin (a biological marker of diabetes), self-reported happiness (thought to be a more global measure of depression), hypertension or high cholesterol. On the other hand, access to high quality ambulatory care is consistently associated with better outcomes for those with diabetes, heart disease, and asthma (Billings, Anderson, & Newman, 1996; Canadian Institute for Health Information, 2013). So while improved access to medical care may not prevent diabetes, hypertension, or other diagnosed leading causes of death, it can be essential in limiting the potentially dangerous long-term consequences of having those conditions.

These findings about the limited improvements to health of expanding insurance are open to several possible critiques. One is that the negative association between expanded coverage and financial strain is not a small matter among poor populations and is likely to have an important long-term influence on physical health, even if not directly through insurance and care (we return to the topic of financial strain, below). A more important shortcoming, perhaps, is that the Oregon study considers a relatively short follow-up time period (about two years), and this may not be sufficient to detect how access to medical insurance directly influences longer-term health outcomes (Gomez & Artiga, 2011).

More recent research has shown positive impacts of insurance coverage on health and well-being. First, studies in two states with near universal coverage – Hawaii and Massachusetts – show lower mortality rates among their residents compared to states with lower rates of insurance coverage (Levey, 2014a; Sommers, Long, & Baicker, 2014). For example, in Texas, the state with the lowest rate of insurance coverage in the country, residents are 40 percent more likely to die of breast cancer than residents in Hawaii according to data from the U.S. Centers for Disease Control and Prevention, U.S. Census, and the Commonwealth Fund, a private foundation seeking to improve the healthcare system (Levey, 2014a). These lower mortality rates among the insured are largely attributed to better access of clinical services – both in treatment but also early detection of illnesses that are associated with mortality rates such as cancer or cardiovascular disease (Levey, 2014a; Sommers et al., 2014).

A Harvard University study on the impact of insurance status also showed that young adults who were insured were more likely to report being in excellent physical and mental health than those who were not insured (Chua & Sommers, 2014). Furthermore, coverage has been shown to reduce psychological distress, increase use of medical services, establish usual sources of care, and improve the continuity of care; all of these effects of expanded coverage are arguably positively associated with long-term individual health (Ezekiel, 2014; Gomez & Artiga, 2011; Stevens, Cousineau, A., & Lee, 2011). In California, an evaluation of the pre-ACA expansion to low-income adults found that after three years, new health insurance coverage reduced both emergency department and hospitalization use (Kominski et al., 2014).

A more recent CDC review of the likely impacts of insurance expansion under ACA projects that increased use of medication to treat hypertension will result in 110,000 fewer new coronary heart disease events and 63,000 fewer strokes by 2050 (The Commonwealth Fund, 2015; Li, Bruen, Lantz, & Mendez, 2015). This is in line with previous research from the Institute of Medicine (2009) that suggested that, among other things, having insurance was associated with having cancer diagnosed at an earlier stage. In short, while some connections between medical insurance and health outcomes are not always present, the common sense notion that you are better off with than without insurance seems to hold sway.

As for immigrants, using data from a series of focus groups with outreach and enrollment professionals that serve immigrant communities, a 2011 Kaiser Foundation paper finds that Medicaid and the CHIP have been linked to broad quality of life improvements for immigrant families by providing access to preventative and primary care as well as health education, and connecting immigrants to other social services for which they are eligible (Gomez & Artiga, 2011). A 2014 study of California's immigrants showed that the undocumented and uninsured – adults and children – visited doctors' offices significantly less than their counterparts, which indicates less preventative care, including things like cancer screenings (Pourat, Wallace, Hadler, & Ponce, 2014). While medical insurance is only one of many determinants of health (Braveman, Egerter, & Williams, 2011), the evidence suggests that access to insurance and care can indeed improve individual and population health, and that the effects hold for immigrants as well as non-immigrants.

What is the Relationship between Insurance and Financial Stress?

While there are some debates about the role of medical insurance and health, the evidence is clear that lacking health insurance can be financially risky and likely stressful. In California, 2.6 million non-elderly individuals had some kind of medical debt in 2009, an increase of 400,000 people since 2007 (Lavarreda et al., 2012). Predictably, the uninsured are most at-risk for running into debt and serious financial catastrophe due to illness: the same report found medical debt to be significantly higher among those uninsured year-round (18.4 percent had debt) as well as those uninsured part of the year (23.2 percent had debt) compared to those with employment-based coverage (9.1 percent reported medical debt) (Lavarreda et al., 2012). This makes sense considering uninsured patients pay for more than one-third of their care out-of-pocket and are often charged higher amounts than the insured (Hadley, Holahan, Coughlin, & Miller, 2008). For those uninsured who are able to pay down their debt, it is usually from tapping into their accumulated assets intended for another purpose, such as retirement (Cook, Dranove, & Sfekas, 2010) – or for some, turning to predatory lenders that only further damages financial stability (Daly, Oblak, Seifert, & Shellenberger, 2002).

Indeed, a national study found that fully 62 percent of all bankruptcies in 2007 involved medical debt, an increase from 46 percent of bankruptcies in a 2001 survey; and 92 percent of the medical debtors had medical debts over $5000, or 10 percent of pretax family income (Himmelstein, Thorne, Warren, & Woolhandler, 2009). This same study found that out-of-pocket medical costs were the highest for the uninsured patients among those who filed for bankruptcy: they averaged $26,971 for uninsured patients, compared to $17,749 for those with private insurance at the outset, $14,633 for those with Medicaid, $12,021 for those with Medicare, and $6,545 for those with Veterans Affairs/military coverage. Those who had private coverage but then lost it paid an average of $22,568 in out-of-pocket expenses.

A 2010 study found lack of insurance to be decisive in whether illness might result in financial ruin: uninsured near-elderly Americans who experienced a new major illness lost between one-third and one-half of their accumulated assets (Cook et al., 2010). Thus, these uninsured households "appear to be one illness away from financial catastrophe;" in contrast, the study reported that health insurance appeared to offer some financial protection, at least in the short-term (Cook et al., 2010, p. 418). Similarly, a Kaiser Family Foundation national survey in 2000 found that four out of ten (39 percent) uninsured adults reported problems paying medical bills and over a quarter (27 percent) said that these problems had a major impact on themselves and their families. In contrast, only about seven percent of insured people reported a major impact (Daly et al., 2002). By 2008, Kaiser reported that fully half of the

uninsured say paying for healthcare is a serious problem (Kaiser Family Foundation, 2008).

This problem shows up in other ways: uninsured patients are much less likely to seek healthcare for fear of not being able to pay the bill (Kaiser Family Foundation, 2013a). For instance, in 2009 in California, uninsured children and adults were significantly more likely to report not seeing a health care provider in the past year (just under 42 percent of children and 50 percent of adults) than children and adults with employment-based insurance (over 8 percent and 13 percent, respectively) (Lavarreda et al., 2012). Nationally, in the same year, 37 percent of adults under age 65 who were uninsured did not receive, or delayed, needed medical care in the past year due to cost, compared with 9 percent of adults with private coverage and 14 percent of adults with Medicaid (American College of Physicians, 2012).

A quarter of people who owed money to a health care facility said debt would deter them from seeking *future* care (Daly et al., 2002). Not getting regular healthcare means that ailments are allowed to become more serious before treatment is sought – and this results in more costly care (Kaiser Family Foundation, 2013a). That is, the uninsured individuals get less care, but risk paying much more when they do – both because their condition is likely more serious, but also because, as noted above, they are charged more than the insured (Hadley et al., 2008). When finally hospitalized, mortality is higher for the uninsured than the insured (Dorn, 2008; Hadley et al., 2008).

While these studies do not look specifically at undocumented immigrants, the literature is relevant since the undocumented have much lower levels of insurance coverage and are generally already in financially precarious situations. Those few studies that do look at undocumented immigrants in California confirm that the threat of medical debt due to lack of insurance is part of their experience. In 2013, the Kaiser Family Foundation conducted a survey of uninsured adults in California which included a subsection focusing on undocumented residents, who are estimated to make up one-fifth of the uninsured in the state (Kaiser Family Foundation, 2013a).[11] The poll revealed that 82 percent of these respondents want health insurance and that 79 percent think that the most important reason to have health insurance is "to protect against high medical bills in case of severe illness or accident" (Kaiser Family Foundation, 2013a). In addition, the financial stress or concern that comes from lack of insurance is being added to another constant stress for the undocumented: the fear of deportation (Dreby, 2015; Partners, 2013).

Why Should Others Care About Undocumented Access to Health Insurance?

While concern about immigrant well-being – in terms of physical health, financial stability and emotional security – is certainly a good reason to care about expanding access to health insurance, there are other reasons which involve benefits to the entire population. For example, estimates generated by applying the 1994 LAC-MIHLSS I and 2001 LAC-MIHLSS II legal status predictors to foreign-born adult Mexican immigrants in 1998-2005 National Health Interview Survey (NHIS) data suggest that unauthorized immigrants are younger and healthier than the authorized U.S. population on average (Marcelli, 2007). This implies that their use and the associated costs of medical care are lower on average than those of other U.S. residents. Indeed, in a study by the UCLA Center for Health Policy Research using the

[11] For the purposes of the survey, Kaiser Family Foundation defined undocumented immigrants as "those that reported a) they were not born in the United States, and b) they came to this country without a green card, and c) they have not received a green card or become permanent residents since arriving." See Section 5 of the report for more details: (Kaiser Family Foundation, 2013a).

2009 California Health Interview Survey, researchers found the undocumented and uninsured used medical services less than their counterparts; while we discuss the reasons for this later, the point here is that adding this group to the pool does not necessarily add a disproportionate demand or strain on the system (Pourat et al., 2014).

It could also help bring down (or at least slow the growth of) medical premiums. The success of private medical (and other types of) insurance programs depends on risk sharing, where a relatively large number of low-risk or low-cost people pay to help spread the costs of a smaller number of expensive cases (Artiga, 2013). This is why there has been so much attention to the number of young adults enrolling under the health care exchanges – 2.2 million (or about 28 percent) of those who have signed up for insurance during the ACA's first open enrollment season, are between the ages of 18 and 34 (Department of Health and Human Services, 2014). There is no reason to suspect that the economic surplus or diversification of the insurance pool attributable to young adults in general would not occur with the inclusion of unauthorized immigrants who are also generally younger than the U.S.-born population.

Indeed, by excluding undocumented immigrants from obtaining insurance on the new exchanges, the cost of healthcare for those who are insured may increase to cover uncompensated care for the uninsured (Artiga, 2013). Insuring all Californians will reduce future costly public emergency room visits – the costs of which are passed on to those paying into the insurance pools (Brown, et al., 2004; Pauly & Pagán, 2007). Extending coverage may also help reduce public spending on uncompensated care, since in California counties have the ultimate responsibility for the health of all residents and thus pay for much of the care of uninsured residents (authorized or not) through county hospitals and hospitals under county contracts. Not only could uncompensated care costs decrease in the short- to medium-term, insurance would facilitate access to preventive and early care that would help patients avoid costly procedures and treatment in the long run (Castrejon, Estudillo, Gutierrez, & Ramirez, 2013). Given the low incomes of most of the undocumented, these costs would likely be covered by safety net programs (Pourat et al., 2014). So, incorporating the undocumented into medical insurance exchanges can be part of reducing strain on the overall state of the safety net.

Yet another reason to consider how access to insurance and health care for the undocumented could improve outcomes for all Californians involves the role of unauthorized immigrant residents in the workforce. Such immigrants tend to work in relatively risky and undesirable low-skill jobs (Berlinger & Gusmano, 2013), often at pay rates that essentially subsidize the consumption patterns of others. Low-skilled immigrants also improve the job specialization and productivity of higher-skilled native workers, as when lower wage workers in apparel help keep higher-paid fashion design thriving, or when the role of immigrant labor in agriculture helps keep afloat better renumerated jobs in farm management, trucking, and related industries (Peri, 2012). Together, all residents benefit when the health of California's workforce is maintained. And there can be direct economic benefits for the non-immigrant population as well: low-income health programs increase the demand for healthcare workers, medical supply companies, and other related economic activities (Lucia, 2011) that often employ high- and mid-skill workers, which is especially critical in an economy which has raised concerns about a disappearing middle class.

II. UNDOCUMENTED AND UNINSURED

So if being undocumented and uninsured is problematic for both immigrants and the broader society, what exactly is the size of this population? In this section, we discuss the estimation strategy used in this particular effort, then report on some broad trends in the data for California and the BHC sites.

Photo by the California Immigrant Policy Center

ESTIMATING THE SIZE OF THE UNDOCUMENTED POPULATION: METHODS

Early demographic estimates of the number of unauthorized immigrants entering (Frisbie, 1975; Heer, 1979) or residing in (Bean, King, & Passel, 1983; Robinson, 1980) the entire U.S. relied on limited data and questionable assumptions regarding sex ratios as well as mortality, emigration and census undercount rates (Bos, 1984; K. Hill, 1985). Subsequent studies brought improved methods, generally by using a version of the so-called "residual" method which subtracted those estimated to be legally residing in the U.S. from the total foreign-born population counted in the Census or large surveys (Hoefer et al., 2012; Hoefer et al., 2011; Hoefer, Rytina, & Campbell, 2006; Passel, 2005; Passel & Cohn, 2009, 2011; Passel & Woodrow, 1984; Warren, 2003; Warren & Passel, 1987; Woodrow & Passel, 1990).

Currently, the most well-known sets of these residual-derived estimates provide very similar estimates of the number of unauthorized immigrants residing in the U.S. and California. Specifically, the Pew Hispanic Center has traditionally started with the number of non-naturalized foreign-born residents of the U.S. in the March CPS, then subtracted the number of those estimated to be residing in the country legally based on Immigration and Customs Enforcement (ICE) and other data (the estimates also involve some adjustment for the likelihood that the Census may undercount unauthorized residents). The difference is assumed to be the unauthorized immigrant population which in 2010 was estimated to be approximately 10.8 million persons nationally and about 2.6 million in California (Passel & Cohn, 2011). As of 2012, the Pew researchers shifted the source of the data for non-naturalized immigrants from the CPS to the ACS data; for that and other reasons, these estimates were revised to 11.7 nationally and 2.5 million in California (Passel et al., 2013). The most recent national PEW estimate for 2014 is 11.3 million (Krogstad & Passel, 2015).

The method used by the U.S. Department of Homeland Security's Office of Immigration Statistics also starts with the number of non-naturalized foreign-born residents from ACS data and subtracts figures it has on the number of non-citizen immigrants estimated to be residing in the country legally. That method comes up with very similar results: the Department of Homeland Security initially (as of January 2010) estimated that there were approximately 11.2 million unauthorized immigrants residing in the U.S., 2.6 million of whom were residing in California (Hoefer et al., 2011) and subsequently estimated that about 2.8 of 11.5 million unauthorized immigrants were residing in California (Hoefer et al., 2012). A third separate study employing a residual methodology estimates that in 2010, 2.9 of 11.7 million (or 24.8 percent) of all unauthorized U.S. immigrants resided in California

(Warren & Warren, 2013). Thus, demographers through slightly different residual-based methodologies have been making national- and state-level estimates of the number of unauthorized immigrants for three decades, and the most recent estimates suggest that California is home to 2.5–2.9 million of the 11.2–11.7 million unauthorized immigrants in the country (with recent estimates from the Migration Policy Institute suggesting a larger number for California than those offered by other experts) (Migration Policy Institute, 2014).

While the residual strategy essentially starts from the top of the data pile and drills down, a second approach pioneered by two USC (at the time) demographers (including one of the authors of this report), starts from the ground up. Known as the community-based migrant household probability sampling method (Marcelli, 1999, 2014; Marcelli & Heer, 1997, 1998), this strategy is one in which researchers work directly with a community-based organization to develop a questionnaire that enables immigrant interviewers to collect legal status information that is not typically available in most large population-based surveys.

The resulting 1994 and 2001 Los Angeles County Mexican Immigrant Health & Legal Status Surveys (LAC-MIHLSS I and II) provided the first random household survey data that allowed researchers to independently estimate the number, characteristics, and effects of unauthorized immigrants residing in a particular sub-state area (Granberry & Marcelli, 2007, 2011; Marcelli, 2001, 2004a; Marcelli & Lowell, 2005; Marcelli & Ong, 2002).

To then derive population estimates, the next step in this process has typically involved developing demographic predictors of unauthorized legal status from the survey (e.g., age, sex, educational attainment, years residing in the U.S.). These predictors are then applied to individual respondents in the U.S. Census and other surveys (e.g., ACS, CPS) to estimate the probability that any particular non-naturalized foreign-born resident in the survey is an unauthorized immigrant.

These can be then applied to various geographic levels or to ask questions such as whether or not there are significant wage differences between documented and undocumented workers (Brown & Yu, 2002; Pastor Jr., Scoggins, Tran, & Ortiz, 2010). While the community-based approach involves immigrant interviewers, others have taken a similar approach with random household surveys (e.g., CHIS, LAFANS) and began asking variants of the three main LAC-MIHLSS I legal status questions in the early 2000s (Brown, Holtby, Zahnd, & Abbott, 2005; Brown et al., 1998; Goldman et al., 2005).

Most recently, some demographers have developed a third approach that involves deriving legal status predictors by making use of responses from a wave of the Survey of Income and Program Participation (SIPP) that includes questions and responses on the nature of documentation upon arrival and current status (James D. Bachmeier, Leach, Bean, & Van Hook, 2012; Capps et al., 2013). Despite early criticism by some prominent demographers who doubted unauthorized immigrants would be forthcoming about their legal statuses or even participate in surveys (Jasso, Massey, Rosensweig, & Smith, 2004; Massey & Bartley, 2005; Massey & Capoferro, 2004; Van Hook & Bean, 1998), legal status predictors generated from information that is self-reported in relatively smaller sample surveys are increasingly applied to public-use data to investigate issues related to unauthorized immigration. The third SIPP-based approach is what we take in this particular report.

THE GEOGRAPHY OF UNAUTHORIZED IMMIGRANTS

While making national level estimates is important, driving estimates down to increasingly local levels has proved popular. For example, drawing on the work of former Department of Homeland Security demographer Robert Warren, researchers from the Public Policy Institute of California (PPIC) estimated the number of unauthorized immigrants in California by county and zip code using the estimated relationship between 2001-2008 state-level estimates and IRS Individual Tax Identifier Number (ITIN) filings (L. E. Hill & Johnson, 2011; Warren, 2011). The two co-authors of this report also offered a series of county-level estimates for California in a report called *What's at Stake for the State: Undocumented Californians, Immigration Reform and Our Future Together* (Pastor & Marcelli, 2013).[12]

In this current report, we are trying to drive the estimates down to an even finer level of geography – the BHC communities that are part of the Building Healthy Communities program of The California Endowment. As noted, to do that, we are utilizing estimates derived from an analysis of responses to questions in the Survey of Income and Program Participation, or SIPP. The results are not dissimilar to what might be derived from the community-based probability approach, and the strategy may be better for non-Mexican immigrants (since the community surveys that underlie that approach have generally focused on specific populations, such as Mexicans in California and Brazilians and Dominicans elsewhere). The basic approach, described in the Appendix, is to first assign documentation status based on "logical" conditions (such as the fact that military veterans are not likely to be undocumented), and then to utilize information from SIPP to assign probabilities of being unauthorized. A sorting procedure is then used to mimic the underlying probability distribution and estimates of country of origin and state totals are used to constrain and refine the estimates.

With this method in place, we are able to produce population profiles from a tailored dataset that pools 2008-2012 data from the ACS. We then derive a profile for California as well as data and profiles for the BHC sites. A special procedure, described in the Appendix, is used to insure that the BHC estimates line up with population and income characteristics that can be derived from tract-level summary data for those communities.

As Figure 1 on the next page shows, 72 percent of California residents are citizens, 12 percent are naturalized citizens, 7 percent are authorized immigrants, and 8 percent are unauthorized immigrants. We were also able to look at these different "status" breaks by English language ability and poverty. For example, 18 percent of naturalized immigrants are below 150 percent of the poverty line, whereas the same is true for 21 percent of the U.S.-born; however, a startling 44 percent of unauthorized immigrants live in families with incomes below 150 percent of the poverty line. This is, in short, an economically distressed population.

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[12] In addition to these county-level studies, there are estimates for selected metropolitan areas or congressional districts using other methods (Fortuny, Capps, & Passel, 2007; Paral, 2006).

Figure 1: Population Profile of California

2008-2012 Population Profile: Building Healthy Communities California

TOTAL POPULATION	37,530,341	
Race and Ethnicity		
Non-Hispanic White	14,988,882	40%
Latino	14,193,728	38%
Asian or Pacific Islander	5,012,085	13%
Black	2,155,209	6%
Other	1,177,476	3%
Nativity and Legal Status		
U.S.-born (U.S. Citizen)	27,190,335	72%
Foreign-born ("Immigrant")	10,340,006	28%
Naturalized Immigrant (U.S. Citizen)	4,680,133	12%
Authorized Immigrant (Non-U.S. Citizen)	2,704,591	7%
Unauthorized Immigrant (Non-U.S. Citizen)	2,955,282	8%
Speaks English Well (among Those Age ≥ 5 Years Old) [1]	31,027,660	89%
Immigrant	6,592,059	64%
Naturalized Immigrant	3,650,549	78%
Authorized Immigrant	1,650,029	61%
Unauthorized Immigrant	1,291,481	44%
Poverty (Family Income < 150% of Poverty Line) [2]	8,607,826	23%
U.S.-born	5,672,692	21%
Immigrant	2,935,134	28%
Naturalized Immigrant	855,631	18%
Authorized Immigrant	781,463	29%
Unauthorized Immigrant	1,298,040	44%

INSURANCE/COVERAGE FOR WORKING AGE POPULATION (25-64)		
Has Medical Insurance Coverage	15,286,851	76%
U.S.-born	10,328,857	84%
Immigrant	4,957,994	65%
Naturalized Immigrant	2,785,811	81%
Authorized Immigrant	1,266,094	63%
Unauthorized Immigrant	906,089	41%
Has Employer-Sponsored Medical Insurance Coverage	11,308,073	57%
U.S.-born	7,795,316	63%
Immigrant	3,512,757	46%
Naturalized Immigrant	2,091,244	61%
Authorized Immigrant	855,666	43%
Unauthorized Immigrant	565,847	26%
Has Low-Income Government Insurance or Assistance (e.g., Medi-Cal) [3]	2,181,328	11%
U.S.-born	1,288,873	10%
Immigrant	892,455	12%
Naturalized Immigrant	345,309	10%
Authorized Immigrant	260,039	13%
Unauthorized Immigrant	287,107	13%

CHILD POPULATION (< 18 YEARS OLD)	9,266,556	
Nativity and Legal Status		
U.S.-born	8,726,072	94%
Immigrant	540,484	6%
Unauthorized Immigrant	272,215	3%
Resides with at Least One Immigrant Parent [4]	4,415,328	48%
of those children, share US-born	3,936,467	89%
Resides with at Least One Unauthorized Immigrant Parent [4]	1,785,809	19%
of those children, share US-born	1,492,386	84%
Child Poverty (Family Income < 150% of Poverty Line) [4]	2,993,785	32%
Resides with ≥ 1 U.S.-born Parent	1,237,547	24%
Resides with ≥ 1 Immigrant Parent	1,755,923	40%
Resides with ≥ 1 Naturalized Parent	481,453	24%
Resides with ≥ 1 Authorized Immigrant Parent	593,866	40%
Resides with ≥ 1 Unauthorized Immigrant Parent	1,035,550	58%

UNAUTHORIZED IMMIGRANT POPULATION		
Places of origin		
Mexico	2,055,813	70%
Central America	362,520	12%
Asia	428,593	15%
Rest of the World	108,357	4%
Female	1,358,616	46%
Age and Time in Country (Medians)		
Age	32 years	
Age First Arrived in Country	20 years	
Years Residing in the USA	10 years	
Labor Force Participation (Age 18-64 Years Old)	1,994,523	75%
Male Participation	1,305,074	90%
of which, share employed	1,188,122	91%
of employed, share full-time	805,802	68%
Female Participation	689,449	57%
of which, share employed	584,215	85%
of employed, share full-time	317,709	54%
Top 5 Industries	1,110,369	73%
Retail Trade	322,781	21%
Manufacturing	220,288	15%
Agriculture, Foresting, Fishing and Hunting	210,997	14%
Construction	201,629	13%
Business and Repair Services	154,674	10%
Top 5 Occupations	817,874	54%
Farming, Forestry, and Fishing Occupations	210,879	14%
Food Preparation and Service Occupations	170,616	11%
Helpers in Construction and Freight	156,428	10%
Machine Operators, Assemblers, and Inspectors	141,216	9%
Cleaning, Building and Household Service Occupations	138,735	9%

Notes

* indicates that the underlying number of observations is too small to make a reliable calculation of the variable in question.

[1] Virtually all U.S.-born respondents in the ACS either report speaking English very well or speak no other language but English at home.

[2] These are computed at the individual level using the ACS variable indicating the ratio of family income to the poverty line by family type.

[3] Employer and low-income insurance coverage do not add up to total coverage which also includes private purchased insurance, veteran coverage, etc.

[4] The denominator is the number of children residing with at least one parent.

Methodology

The results in this fact sheet are based on a three-step method the USC Center for the Study of Immigrant Integration (CSII) uses to estimate the undocumented. Starting with the pooled 2008-2012 American Community Survey (ACS) Public Use Microdata Sample data, the first step involves determining who among the non-citizen population is highly unlikely to be undocumented based on certain characteristics. The second step calculates the probability of being undocumented for the remaining non-citizen population by applying coefficients based on a regression analysis of data from the 2008 Survey of Income and Program Participation. The third step then utilizes these strict cut-offs and probability estimates to fit the ACS microdata to national aggregate estimates for the undocumented by country of origin.

The main focus of this report is on health and health insurance, so we also looked at insurance coverage for the working age population. Among all California residents ages 25-64, about 76 percent have medical insurance, though there are great disparities when residents are parsed out by immigration status. While 84 percent of the U.S.-born have coverage, only 65 percent of immigrants and 41 percent of unauthorized immigrants are insured. Unauthorized Californians who do have medical insurance tend to have employer-sponsored coverage (26 percent); only 13 percent gain coverage from low-income government insurance or assistance.

Some may wonder how it is that the undocumented could have such government assistance since presumably they are barred from accessing these services. There are likely at least two reasons. First, the Census question is broad enough that some may be answering in the affirmative on receiving government assistance because they are taking advantage of community health clinics. Second, the undocumented do receive some assistance (especially emergency care) and one report utilizing 2010 data lists over 800,000 undocumented residents in CA with Emergency MediCal (California Healthcare Foundation, 2013). Since one can apply for a "restricted Medi-Cal" (i.e. emergency MediCal only) card at any time, it is likely that a number of the undocumented respondents who report having Medi-Cal do have a Medi-Cal card that can only be used for a very restricted scope of services.

One can also look at specific characteristics of unauthorized Californians. For example, among the state's unauthorized residents, 70 percent are from Mexico, 15 percent from Asia, 12 percent from Central America, and 4 percent from the rest of the world. Perhaps unsurprisingly, given that many unauthorized immigrants come to work and lack access to most public benefits, 75 percent of unauthorized immigrants are in the labor force, with men having higher participation rates (slightly over 90 percent) than women. Statewide, unauthorized residents tend to work in Retail Trade; Manufacturing; Agriculture, Foresting, Fishing and Hunting; Construction; and Business and Repair Services.

One fascinating aspect revealed in the table is how interwoven the lives of unauthorized immigrants with the children that comprise the future of the state are. While only 3 percent of Californian kids are unauthorized, 19 percent of the state's children live with at least one unauthorized immigrant parent, and of those children, 84 percent are U.S.-born. At odds with the typical narratives around California's undocumented population: half of the state's undocumented residents have lived in the country for at least 10 years. While not directly in the table, it is also useful to note that a full 20 percent of undocumented heads of households are homeowners. All of this suggests the deep roots this population actually has in the state and the embeddedness of undocumented immigrants into the very fabric of California.

In this research, we also drove the data down to the BHC sites (see the comparative tables directly below and the more detailed site profile tables in Appendix B) with a process noted above and described in detail in Appendix A. Figure 2 on the next page shows the location of the BHC sites and Figure 3 on page 20 shows some data comparing a few key characteristics for California and the BHC sites.

Figure 2: BHC Sites in California

Looking at BHC data in Figure 3, we can see that the Central Santa Ana site has the largest share of unauthorized Californians (27 percent) with East Salinas, South L.A., East Oakland, and Boyle Heights not far behind. Only one of the BHC sites (Del Norte) has a smaller share of unauthorized among its total population than the state average of 7 percent. Given this pattern, it is unsurprising that the BHC sites also have a higher share of children with unauthorized parents. Statewide, 19 percent of children have at least one unauthorized parent. In the BHC sites, that share rises to 36 percent and over half of the sites have a rate higher than that (e.g., 50 percent in Central Santa Ana, 46 percent in Boyle Heights, and 36 percent Central West Long Beach).

With regard to medical insurance coverage, medical coverage for the unauthorized is at its highest in Richmond where 54 percent of unauthorized, working-age residents are covered; note, however, that Richmond is somewhat of an anomaly and in other BHC sites where numbers of undocumented residents are higher, as in South Los Angeles, the rate of insurance is much lower (at 25 percent, the lowest of any of the sites). Southwest and East Merced has the highest rate of government-assisted coverage (24 percent) among that same universe of people, while East Salinas has the lowest (8 percent). Other types of coverage are rare across the state. This suggests that different types of interventions are required to shore up medical coverage across the state.

One factor connected to medical insurance rates is industry type – and this is a reason to include industry and occupational breakdowns in this type of analysis. For example, while we do not include the county totals in this report, 41 percent of the unauthorized residents in Alameda County are uninsured while that share is 59 percent in Fresno County. Of course, in Fresno County, 49 percent of employed unauthorized residents work in Agriculture, Forestry, and Fishing whereas in Alameda County, only 5 percent work in that industry and a much higher share work in Retail Trade, Construction, and Manufacturing. The presence of industries with generally lower labor standards will likely lead to lower rates of medical insurance. Indeed, Fresno County has the lowest rate of employer-sponsored medical insurance coverage (15 percent) among the counties analyzed while Alameda has the largest rate (40 percent).

Regardless of the specifics, what is clear is that a breakdown of insurance by nativity indicates that, as previously indicated in the literature review, there is a significant gap in terms of medical insurance coverage for undocumented immigrants in the Golden State. This is certainly a problem for those residents – but it is also a challenge for a next generation of Californians who are almost entirely U.S.-born but being raised by parents who lack legal status and often lack insurance. Guaranteeing a more secure future for these children – and indeed the state – is partly dependent on what we can do to insure appropriate coverage and health security.

Figure 3: 2008-2012 Population Profile, BHC Sites and California

2008-2012 Population Profile: BHC Sites								
Region	*Total Population*	*Non-Hispanic White*	*Latino*	*Asian or Pacific Islander*	*Black*	*Other*	*Unauthorized Immigrant (Non-U.S. Citizen)*	*Children Residing with at Least One Unauthorized Immigrant Parent*[3]
City Heights	84,396	12%	55%	18%	13%	2%	14%	31%
East Coachella Valley	34,618	2%	97%	0%	1%	0%	19%	48%
Central Santa Ana	78,635	2%	94%	3%	1%	1%	27%	50%
Central West Long Beach	84,638	6%	62%	16%	13%	2%	17%	36%
South Los Angeles	91,793	1%	78%	1%	19%	1%	25%	46%
Boyle Heights	92,682	2%	94%	3%	1%	1%	21%	46%
Del Norte County	28,252	64%	18%	3%	4%	11%	2%	6%
South Sacramento	71,599	21%	41%	21%	12%	4%	9%	23%
Richmond	40,870	5%	59%	5%	28%	2%	20%	40%
East Oakland	89,737	4%	51%	6%	37%	3%	18%	34%
Southwest & East Merced	62,660	22%	62%	9%	4%	2%	11%	26%
Central, Southeast & Southwest Fresno	101,900	7%	71%	11%	9%	2%	14%	24%
East Salinas	55,018	4%	92%	2%	0%	1%	23%	44%
South Kern	75,943	12%	82%	2%	3%	2%	14%	29%
All BHC Sites	992,741	9%	70%	8%	11%	2%	17%	36%
California	37,042,462	40%	38%	13%	5%	4%	7%	19%

Adult (25-64) Population								
	Poverty (Family Income < 150% of Poverty Line)[1]		**Has Medical Insurance Coverage**		**Has Employer-Sponsored Medical Insurance Coverage**		**Has Low-Income Government Insurance or Assistance (e.g., Medi-Cal)**[2]	
Region	*U.S.-born (U.S. Citizen)*	*Unauthorized Immigrant (Non-U.S. Citizen)*	*U.S.-born (U.S. Citizen)*	*Unauthorized Immigrant (Non-U.S. Citizen)*	*U.S.-born (U.S. Citizen)*	*Unauthorized Immigrant (Non-U.S. Citizen)*	*U.S.-born (U.S. Citizen)*	*Unauthorized Immigrant (Non-U.S. Citizen)*
City Heights	40%	51%	63%	35%	54%	17%	13%	15%
East Coachella Valley	44%	67%	49%	25%	55%	12%	14%	13%
Central Santa Ana	38%	45%	52%	38%	54%	27%	11%	10%
Central West Long Beach	49%	51%	64%	39%	46%	17%	24%	22%
South Los Angeles	54%	63%	45%	25%	39%	9%	25%	15%
Boyle Heights	46%	59%	51%	32%	44%	12%	21%	17%
Del Norte County	23%	14%	73%	44%	45%	16%	24%	32%
South Sacramento	39%	62%	72%	33%	60%	14%	16%	17%
Richmond	38%	45%	69%	54%	51%	36%	23%	17%
East Oakland	43%	45%	69%	44%	49%	23%	26%	20%
Southwest & East Merced	38%	62%	71%	48%	50%	23%	24%	24%
Central, Southeast & Southwest Fresno	56%	71%	62%	35%	37%	11%	31%	23%
East Salinas	44%	58%	60%	38%	60%	30%	13%	8%
South Kern	42%	61%	66%	44%	48%	24%	23%	20%
All BHC Sites	44%	56%	63%	37%	40%	19%	18%	17%
California	21%	44%	76%	41%	63%	26%	10%	13%

Notes

1 These are computed at the individual level using the ACS variable indicating the ratio of family income to the poverty line by family type.

2 Employer and low-income insurance coverage do not add up to total coverage which also includes private purchased insurance, veteran coverage, etc.

3 The denominator for these computations is the number of children residing with at least one parent.

III. Broadening Access to Health Care

The previous sections explained how extending health insurance to all could have benefits – and our quantitative estimates suggest that there is a large population that is both undocumented and uninsured, particularly in the lower-income communities that are part of the BHC program being undertaken by TCE. But is extending insurance enough? How do immigrants actually access care and what else needs to be done to promote health? In this section, we discuss likely take-up as well as current methods of accessing care. We then turn to some policy recommendations. But first, we take up a few concerns about whether extending health insurance to the undocumented actually makes policy sense.

What Concerns Exist about Extending Access to Health Insurance?

One immediate objection to extending medical insurance to undocumented residents is the worry that this will act as another magnet to draw migrants to the country (leading to more users, higher costs, and sort of spiraling fiscal crisis). Pourat and colleagues (2014), as well as Yang and Wallace (Yang & Wallace, 2007), note that there is little evidence to substantiate this view and it is noteworthy that net migration from Mexico seems to have hit zero in recent years (Castañeda, Wallace, et al., 2014), suggesting a stabilization of the undocumented population that shows up in national estimates even as health insurance is expanding.

Others may question the fairness of allowing undocumented immigrants to benefit at all from public services. The problem with this argument is

Photo by KRC LA

that it essentially assumes that such immigrants are not actually contributors to the public resources which they might access. However, researchers estimate that undocumented immigrants in California pay $2.7 billion annually in sales, income and property taxes (Castrejon et al., 2013; R. Coleman, 2012) – and receiving services in return could make sense, particularly if there are spillover benefits to the general population (which we discuss later).[13]

A more reasonable concern may be the fact that there are pent-up demands for health care and so system reform could introduce an initial shock that would be hard to handle. Studies have consistently shown that the amount spent on healthcare for undocumented immigrants is significantly less compared to the amount spent on U.S.-born citizens. For instance, recent Medical Expenditure Panel Survey (MEPS) data show that only about eight percent of unauthorized immigrants (compared to some 30 percent of U.S.-born citizens) benefit from publicly-subsidized medical care. Those who do benefit receive approximately $140 (compared to $1,385 among U.S.-born citizens) worth of care per year (Stimpson et al., 2013). When comparing

[13] Looking at all immigrants nationally, one study suggests that immigrants contributed $115.2 billion more to the Medicare Trust Fund than they utilized between 2002-2009 (Zallman, Woolhandler, Himmelstein, Bor, & McCormick, 2013). The majority of the surplus came from non-citizen immigrants who are largely working-age taxpayers. So, unauthorized immigrants subsidize the health insurance of the elderly and U.S. citizens.

percentages of healthcare expenditures nationally, spending on healthcare for undocumented immigrant men is 39 percent lower and 54 percent lower for undocumented immigrant women as compared to their U.S.-born counterparts. In Los Angeles County, undocumented immigrants who make up 12 percent of the population only account for 6 percent of spending on healthcare (Gusmano, 2012b). Finally, UCLA researchers found that undocumented Californian adults use the emergency room at about half the rate of U.S.-born residents (Pourat et al., 2014).

Why is this important? While some of the limited spending reflects the relative youth and age of the undocumented population, it also suggests that there may be backlogged need if broader access to insurance and care is granted. Of course, the data could be read another way: the very low levels of current spending on the undocumented suggests that there are unmet health needs, which could contribute to public health and economic problems down the line if insurance access remains constricted (Pourat et al., 2014). Thus, we may really face a problem of time consistency: what seems cheap now (restrict access) may cost more later and striking the right temporal balance may even justify an early and immediate temporary bump up in spending.

How much would it cost to spend now to save later? In a 2014 report aptly titled "A Little Investment Goes a Long Way: Modest Cost to Expand Preventive and Routine Health Services to All Low-Income Californians," researchers from UCLA and UC Berkeley were able to estimate the costs of extending health services to all low-income Californians using the California Simulation of Insurance Markets model (CalSIM). Predicting changes in Medi-Cal enrollment and state spending for 2015 and 2019 based on legislation proposed (but not passed – in 2014, Senate Bill 1005; reintroduced in 2015 as SB 4, the Health for All Act; and then passed in modified form to cover only undocumented children) the researchers found that "the net increase in state spending is estimated to be equivalent to 2 percent of state Medi-Cal spending, compared to an enrollment increase of 7 percent" as then projected for 2015. But they also found that the 2 percent figure would be significantly offset by sales tax revenue from the enlarged health sector and from savings from the reductions in county programs that cover the currently uninsured.

If You Build It, Will They Come?

Our discussion thus far suggests specific benefits to immigrants and the general population from expanding access to health insurance and also suggests that concerns about the magnet effects and costs are logically reasonable but likely not important in practice. But if our ultimate objective is not simply insuring people but helping that population achieve and maintain health, we need to understand the factors that explain why many immigrants who are eligible for and could benefit from medical care fail to obtain it. That is, while it is important to guarantee a supply of medical insurance, we must also understand the factors that determine the take-up rate as well as the actual use of health care. This section reviews findings from studies that examine factors that influence whether lawfully residing immigrants actually access public benefits they are legally eligible for – an analysis that can inform the design and implementation of efforts to extend healthcare coverage to unauthorized immigrants.

In one influential report prepared for the U.S. Department of Health and Human Services, researchers examined the range of take-up (enrolling in programs they are eligible for) in three states that varied by (1) foreign-born resident representation, (2) national origin diversity, (3) state-level policies regarding access to the four main service programs for which immigrants are differentially eligible (i.e., Medicaid/ Child Health Insurance Program (CHIP), Temporary Assistance for Needy Families (TANF), Supplemental Nutrition Assistance Program (SNAP)), and (4) both immigrant service program usage and state and local enforcement

participation in the Immigration and Customs Enforcement's "Secure Communities" program. The researchers interviewed 104 officials and leaders of 23 government agencies, 19 community-based nonprofit provider organizations, and 16 nonprofit immigrant advocacy organizations, and they found that many immigrants and/or their children who are eligible for public benefits may never complete an application process for one to four main reasons (Perreira et al., 2012).

The first reason for lagging sign-up is *budgetary and bureaucratic:* program application processes are often very complex and time consuming. Many immigrants are unfamiliar with the American health and human service system and there is no "one-stop shopping" to explain all the various options (Crosnoe et al., 2012), which can lead to eligible participants falling through the cracks simply from not knowing about all of their options. Once they apply, not only can it take a long time for approval, but eligibility guidelines change from year to year and applicant recertification may be required two or more times a year (Crosnoe et al., 2012). Moreover, seemingly basic questions and document requirements can be difficult to answer regarding (1) number of children, "household size," and settlement intentions; (2) social security numbers and the legal statuses of family members; and (3) employment and earnings.

A second reason why eligible immigrants may not complete an application or recertification process is *linguistic and cultural*. Navigating the materials and forms is simply too cumbersome for limited English speaking applicants (Crosnoe et al., 2012) and there is often a shortage of linguistically capable multicultural staff to provide assistance, a situation exacerbated by budgetary cuts that favor retention of employees with more seniority. Also, informal reliance on immigrants' untrained friends or family members (including school-age children) or phone-based interpretation systems may compromise applicant privacy or violate 1996 Health Insurance Portability and Accountability Act (HIPAA) guidelines.

Another cultural factor that may frustrate the application processes is that U.S. public assistance laws define a family as a nuclear family and many immigrants reside in extended- or multi-family housing units. Finally, many immigrants may resist seeking public assistance because they wish to be self-reliant.

A third set of reasons is *logistical*. Many immigrants do not have access to a car (so they rely on public transport services) and do not have secure access to childcare. Inflexible work schedules contribute to difficulty keeping application-related appointments (Crosnoe et al., 2012; Perreira et al., 2012). This is especially true when service provider offices are located far from workplaces or office hours conflict with applicant work schedules. Moreover, many immigrants – particularly those who arrived more recently – do not interact with community-based organizations or have extensive social networks through which they might learn of their eligibility and application procedures or be encouraged to apply (Perreira et al., 2012).

The fourth and final reason is immigration enforcement-related *fear*. Even when immigrant applicants are themselves eligible for public benefits they may decide not to apply because they fear being asked by providers to report other household members' names or social security numbers (some of whom may be unauthorized U.S. residents) (Graves, 2013). "Outing" an unauthorized family member may be perceived as putting them at risk of deportation (Brindis et al., 2014, 2014b; Fremstad, 2000; Graves, 2013; Medina & Goodnough, 2014; Perreira et al., 2012). In other cases, despite the fact that Medicaid (except for long-term care), CHIP, SNAP and non-cash TANF benefits are explicitly excluded from the U.S. definition of a public charge (Fremstad, 2000), many immigrants believe that applying for any public assistance will classify them and/or their children as "public charges" and prevent them from eventually obtaining legal status or citizenship (Medina & Goodnough, 2014).

In short, any approach to extend insurance must be accompanied by an awareness that other structural and cultural factors need to be addressed as well. Becoming authorized or being granted access to insurance even if unauthorized, does not change the bureaucratic, linguistic or logistical dimensions and enforcement will still be an issue. For example, even many young people eligible for Medi-Cal because of their status under DACA have been hampered by delays or local officials being aware of the eligibility of this population (Sundaram, 2014). In reviewing two relatively expansive programs open to undocumented immigrants in San Francisco and Massachusetts, Marrow and Joseph point to how complex documentation, language barriers, and lack of knowledge led to *de facto* exclusion of the undocumented. Thus, any effort to include the unauthorized, either through shifts in national policy or the experiments emerging in California, will need to tackle these demand-side and bureaucratic issues as well.

Fortunately, the state of California is headed in the right direction in terms of taking on these issues. Most community clinics house enrollment assistants who help overcome many of these barriers. And, in June of 2015, the County Welfare Director's Association (in coordination with TCE) published a list of county Welfare Department immigrant liaisons for every county in the state. The liaisons work with immigrants of all statuses and their families to help navigate the Medi-Cal system (#healthforall, 2015). This is an important step forward in addressing the issues raised in this section but such efforts are always complicated by the issues raised earlier: even in Los Angeles, where there has been an aggressive attempt to extend health care to the undocumented through the public health system, the take-up numbers have fallen short of the goals, with observers pointing to the need to create more points of access for enrollment, such as mobile clinics (Karlamangla, 2015b).

Having Insurance, Obtaining Care

Even if access to insurance improves health directly through increased use and quality of medical care or indirectly by diminishing psychological distress (Jouët-Pastré, Ribeiro, Guimarães, & de Azambuja Lira, 2008), coverage is not the only variable that influences whether a person can or does access medical care when desired or needed. Cultural, geographic, and socioeconomic factors help explain whether the insured seek medical care and pursue overall health (Berkman & Kawachi, 2000; Elder et al., 2007; Hovell, Wahlgren, & Adams, 2009). In other words, although it is likely that access to medical insurance has an independent positive effect on individual and population health (Wallace & Brown, 2012), assessing the impact and importance of coverage requires systematic consideration of individual characteristics and behaviors, as well as extra-individual environmental circumstances and conditions.

Other factors influencing immigrant access to medical services may include health status; educational attainment; English proficiency and health literacy; time residing in the U.S.; legal status and associated fears; occupation or work schedule; home environment; neighborhood context; access to affordable childcare and transportation; social networks; and federal, state and local policies affecting the availability and cost of care (Cristancho, Garces, Peters, & Mueller, 2008; Derose, Escarce, & Lurie, 2007; Kirby & Kaneda, 2005). Simply not having a usual source of care will deter even those with benefits or coverage – while long waits, poor perceived quality, and other system factors similarly discourage appropriate use when cost is not a barrier (Artiga, 2013; Stephens & Artiga, 2013).

The role of contextual variables, such as geographic proximity to care, can be critical. For example, using LAC-MIHLSS II data, Marcelli suggests that only 39 percent of Mexican immigrant adults obtained "needed" medical care (Marcelli, 2004b). But multivariate regression

analysis revealed that although receiving care was positively associated with being married and being more civically engaged – and negatively associated with having difficulty finding a medical care facility and residing in a minority neighborhood – neither insurance coverage nor unauthorized legal status were independently significant. Other studies do find unauthorized legal status is negatively and statistically associated with having sought medical care in the previous year (L. R. Chavez, 2012), and with having had a usual place of care or having visited a doctor during the previous year (Bustamante et al., 2012; Pourat et al., 2014).

These results suggest that the effect of immigration status is mediated by (or embedded in) home environment, local or neighborhood socioeconomic conditions (including geographic access to a medical care facility), and broader social networks. Such geographic and social contexts determine the possibility of obtaining needed care and also influence the perception of when care is needed (e.g. low-income, uninsured persons with low education may consider health care as "needed" only in life-threatening instances, while someone with insurance who has more education may consider preventive care and the evaluation of a broader range of symptoms as needed care).

The contextual discussion is important because the undocumented are not randomly distributed geographically for all sorts of reasons, including that it is easier to be supported in an immigrant enclave. Which particular neighborhood context factors matter can be difficult to tease out in statistical work because such variables are highly collinear – that is, factors that move in the same direction (such as percent in poverty and percent linguistically isolated) can each have impact and it can be difficult to distinguish the isolated impact of any one factor on the phenomenon in question. Nonetheless, neighborhood context is important and given unauthorized immigrants' relatively heavy reliance on community-based health clinics (L. R. Chavez, 2012) and recent evidence that they strongly favor these over other possible places of care (Wallace, Rodriguez, Padilla-Frausto, Arrendondo, & Orozco, 2013), future studies should investigate how the geographic proximity of community-based organizations – including clinics – is associated with use of medical services. It would also be useful to investigate through which socio-geographic domains (e.g., home, neighborhood, workplace) unauthorized legal status influences access to medical care.

Health Status, Health Insurance, and Access to Care in Building Healthy Communities Sites

Of course, one important set of neighborhood contexts are reflected in the BHC sites profiled earlier. In the previous section, we reported estimates based on applying logical conditions and probability predictors to secondary Census data (along with geographic fitting) to get at what the likely overall patterns in terms of access to medical insurance are, as well as a number of other socioeconomic variables for each of the BHC communities. That data, however, does not and cannot get at actual health outcomes – those sorts of questions are not asked by the Census. So while the ACS is excellent for some purposes – it is the largest available sample with the individual characteristics we need for unique area estimates – we must turn to other survey instruments to look at actual use of health care as well as health outcomes.

Fortunately, the California Health Interview Survey (CHIS) asks exactly these sorts of questions – and the 2009-10 CHIS collected extra data from the BHC communities to be able to portray their health status accurately.[14]
In examining the CHIS data below – and, in

[14] More detailed profiles of the families in these communities is available at http://healthpolicy.ucla.edu/chis/bhc/Pages/Get-BHC-Data.aspx .

particular, in comparing it with the earlier reported estimates from applying logical conditions and SIPP-based probabilities to the ACS data – there are two important factors to keep in mind. The first is that even with an oversample on the BHC sites, this is still a relatively small sample. So any particular estimate – especially for small populations (such as the undocumented in the Del Norte BHC site where they are a small share of population) may look exact because we see a single number, but there is actually a wide band of potential error. A second issue is that the data presented here from the CHIS are only for children and adults age 18 to 40 and additional adults with children under age 18 (the BHC target group). For both the first and second reasons, the data discussed here will not be strictly comparable with the data presented earlier in the paper.

One way to cross-check the two sources, however, is by comparing rates of medical insurance for undocumented residents by BHC site – having health insurance is both a critical gateway to obtain needed medical care and a way to ascertain the match between these two approaches. In 2009-10 among all Californians ages zero to 40, about 16 percent had no health insurance coverage. In almost all BHC communities (Figure 4 on page 27), more residents than average were uninsured, with the rates being triple or more the statewide average among undocumented residents. People who report insurance most commonly have employment-based insurance; low-income persons most commonly report Medicaid or other public insurance. This is true even for undocumented residents who may qualify for emergency Medi-Cal which is limited in scope, for Medi-Cal during pregnancy which is limited in time, or for a number of county programs for otherwise uninsured children and adults.

How do the numbers compare between the CHIS estimates for the BHC sites and the estimates presented earlier in this report? The good news is quite well. As with the Census data, the rates of uninsured for undocumented residents are much higher than for the rest of the population.

More importantly, the ranges for each BHC site are reasonably close to the Census data estimate shown earlier. For example, the estimation strategy above suggests than in Fresno, 65 percent of working-age undocumented residents lack medical insurance, while CHIS gives us 61 percent; in Long Beach, the estimation gives us 61 percent uninsured, while CHIS gives us 62 percent; in City Heights, the estimation strategy gives us 65 percent uninsured among the working-age undocumented, while CHIS gives us 70 percent; and in East Oakland, the comparison is 56 percent from the estimation strategy and 55 percent in CHIS, while in East Salinas, the comparable figures are 62 percent and 60 percent and in South Kern, the figures are 56 and 53 percent.

Some of the other BHC sites exhibit wider but not wildly divergent differences. In Santa Ana, for example, the estimation strategy deployed earlier suggests that 62 percent of working age undocumented are uninsured, not far away (given both sample size issues and the age restrictions in the CHIS data) from the 78 percent reported in the table below. However, there are some bigger differences worth noting. The most important may be Boyle Heights where we see 68 percent of undocumented residents lacking insurance in the indirect estimating strategy versus 40 percent in the CHIS data; it is hard to know the reasons why these are so different but that is the nature of sampling. In any case, the general story is that the CHIS estimates are very close to the estimates offered earlier – and the utility of CHIS is that it reveals actual use of care.

Figure 4. Uninsured Rates in BHC Communities, CHIS-based Estimates

Uninsured, ages 0-40		
	Documented residents*	*Undocumented Residents*
Boyle Heights	27.2%	40.2%
Central Santa Ana	15.4%	77.6%
Central/Southeast/ Southwest Fresno	23.6%	61.2%
Central/West Long Beach	29.1%	62.4%
City Heights	21.0%	69.8%
Del Norte County	29.2%	47.7%
Eastern Coachella Valley	32.8%	36.6%
East Oakland	30.2%	54.6%
East Salinas	37.1%	59.9%
Richmond	20.3%	70.1%
South Kern (Arvin-Lamont)	21.8%	52.6%
South Los Angeles	23.0%	48.5%
Southwest/East Merced County	27.3%	66.4%
South Sacramento	25.2%	47.4%

Source: CHIS 2009-10
* Note: documented residents include US-born citizens, naturalized citizens, and lawful permanent residents.

Figure 5. Usual Source of Care in BHC Communities, CHIS-based Estimates

No Usual Source of Care, Ages 0-40		
	Documented residents	*Undocumented Residents*
Boyle Heights	17.5%	27.5%
Central Santa Ana	22.3%	52.8%
Central/Southeast/ Southwest Fresno	18.3%	25.0%
Central/West Long Beach	27.8%	32.7%
City Heights	17.3%	23.3%
Del Norte County	17.2%	36.5%
Eastern Coachella Valley	24.2%	27.0%
East Oakland	29.9%	39.3%
East Salinas	25.2%	44.6%
Richmond	11.0%	11.9%
South Kern (Arvin-Lamont)	19.5%	33.9%
South Los Angeles	16.5%	36.3%
Southwest/East Merced County	24.3%	54.0%
South Sacramento	18.8%	31.0%

Source: CHIS 2009-10

Having a usual source of care is one of the best predictors of having regular access to care. This means that there is a place that the person "usually" goes to when they are sick and in need of care, which indicates that they have established some ongoing relationship with a provider site. Statewide, about 18 percent of residents ages zero to 40 report having no usual source of care. In the BHC communities (Figure 5 on the previous page), documented residents have a rate of no usual source of care that is similar or somewhat higher than the statewide rate. The undocumented residents of those communities, however, generally have a rate of no usual source of care that can be double the rate of the documented residents, tracking the variation in health insurance rates (and indirectly suggesting that insurance does indeed matter). Two communities (Central Santa Ana and Southwest/East Merced County) report that over half of undocumented residents indicated that they have no usual source of care. This demonstrates the added barriers that undocumented residents face in knowing where to go for medical care and being able to afford and feel safe regularly accessing services.

Among California residents ages zero to 40 statewide with a usual source of care, about two-thirds have a private doctor or HMO as their usual source, and about one-third report a community or government clinic as their usual source.

The importance of the community health center system is evident in the BHC communities (see Figure 6 on the following page) where documented residents are generally at least as likely to rely on community health centers – and often more likely – while their undocumented neighbors who have a usual source of care are twice as likely or more to report that care coming from a community health center.

Community health centers are important resources in these low-income communities because they serve all residents without regard to income or citizenship. They have sliding-scale fees for those without insurance, and, as independent nonprofit organizations, they are perceived as being "safe" from immigration authorities. As an increasing proportion of documented residents obtain Medi-Cal and Covered California insurance under health care reform, the remaining uninsured are likely to be even more dependent on the community health centers in their communities.

Figure 6. Source of Usual Source of Care in BHC Communities, CHIS-based Estimates

	Usual Source of Care at Community Clinic, ages 0-40		Usual Source of Care at Private MD or HMO, ages 0-40	
	Documented residents	*Undocumented residents*	*Documented residents*	*Undocumented residents*
Boyle Heights	63.0%	79.4%	37.0%	20.6%
Central Santa Ana	39.8%	63.4%	60.2%	36.6%
Central/Southeast/ Southwest Fresno	39.9%	69.7%	60.1%	30.3%
Central/West Long Beach	40.6%	80.1%	59.4%	19.9%
City Heights	54.9%	83.4%	45.1%	16.6%
Del Norte County	49.1%	80.3%	50.9%	19.7%
Eastern Coachella Valley	41.7%	70.9%	58.3%	29.1%
East Oakland	55.0%	85.4%	45.0%	14.6%
East Salinas	27.9%	78.2%	72.1%	21.8%
Richmond	55.6%	84.5%	44.4%	15.5%
South Kern (Arvin-Lamont)	32.0%	67.1%	68.0%	32.9%
South Los Angeles	38.2%	70.9%	61.8%	29.1%
Southwest/East Merced County	50.1%	71.2%	49.9%	28.8%
South Sacramento	29.7%	63.9%	70.3%	36.1%

Source: CHIS 2009-10

The health status of residents of BHC communities is mixed compared to the rest of the state. While these heavily immigrant communities should benefit from the "immigrant health advantage" (where those arriving in the country are generally healthier than those already living here), there are several areas of heightened risk. Overweight and obesity statewide rates among those ages 12 to 40 is about 48 percent, with residents of BHC communities (see Figure 7 on the next page) having higher rates. In general, documented and undocumented residents of BHC communities have rates of overweight and obesity that are not too dissimilar (although more often higher for the undocumented), suggesting a common exposure to the conditions that lead to unhealthy food consumption and inadequate physical activity. Since obesity is a major risk factor for diabetes, cardiovascular disease, and other health problems where minimizing the health damages of the condition is dependent on careful management in primary care, the low rates of a usual source of care suggest worse outcomes in the future for undocumented immigrants.

As for the estimates of diabetes rates, these come from respondents who have been told by a doctor that they have diabetes. Other research indicates that about one-third of those with diabetes do not know they have the chronic disease. Despite the low level of accuracy of the estimates given the small numbers involved, the general trend in most of the BHC communities is for undocumented immigrants to have higher reported rates of diabetes than their documented neighbors, despite having worse access to health care where they could get a diagnosis. This trend is consistent with statewide data (Wallace, Torres, et al 2012) and reinforces the common need of all Californians for access to health care.

Figure 7. Obesity and Diabetes in BHC Communities, CHIS-based Estimates

	Overweight & obesity, ages 12-40		Diagnosed diabetes, ages 18-40*	
	Documented residents	*Undocumented residents*	*Documented residents*	*Undocumented residents*
Boyle Heights	47.4%	68.6%	1.5%	2.0%
Central Santa Ana	62.1%	69.8%	1.4%	2.4%
Central/Southeast/ Southwest Fresno	37.6%	62.1%	1.3%	3.2%
Central/West Long Beach	58.2%	64.3%	1.2%	14.7%
City Heights	69.4%	59.1%	2.7%	2.8%
Del Norte County	53.5%	68.6%	1.9%	5.3%
Eastern Coachella Valley	53.0%	66.2%	0.6%	4.6%
East Oakland	55.9%	67.4%	3.4%	22.3%
East Salinas	55.4%	73.1%	2.5%	5.3%
Richmond	69.1%	39.5%	2.1%	6.0%
South Kern (Arvin-Lamont)	54.5%	59.5%	2.4%	9.9%
South Los Angeles	59.9%	57.9%	4.1%	1.0%
Southwest/East Merced County	61.5%	51.6%	2.1%	5.5%
South Sacramento	54.9%	60.0%	1.5%	5.5%

Source: CHIS 2009-10

* Note, small sample sizes makes the undocumented diabetes estimates of low accuracy except for Richmond, South Kern, South L.A., and Merced.

Local Efforts to Provide Unauthorized Immigrants with Insurance and Care

As we have seen, there are problems statewide for undocumented residents with regard to accessing both medical insurance and actual health care – and these issues are exacerbated in the BHC communities. It is also the case that many of the solutions that are emerging are local, in part because California state law requires counties to provide health care for low-income residents who are uninsured yet do not qualify for Medi-Cal or other federal or state programs. However, counties generally vary in their interpretation of which residents and what type of care they are obligated to cover and the infrastructure they use to deliver services to the medically indigent.

For example, a 2015 study by Health Access, a statewide health care consumer advocacy coalition, found that there is inconsistent treatment of undocumented immigrants across counties. As of March 2015, of the 58 counties in the state, only 10 – Alameda, Fresno, Kern, Los Angeles, Riverside, San Francisco, San Mateo, Santa Clara, Santa Cruz, and Ventura – were providing services to patients beyond emergency care regardless of immigration status and one (Contra Costa) covered undocumented children but not adults. Since that study was published, 35 additional counties in the County Medical Services Program (CMSP) consortium – Alpine, Amador, Butte, Calaveras, Colusa, Del Norte, El Dorado, Glenn, Humboldt, Imperial, Inyo, Kings, Lake, Lassen, Madera, Marin, Mariposa, Mendocino, Modoc, Mono, Napa, Nevada, Plumas, San Benito,

Shasta, Sierra, Siskiyou, Solano, Sonoma, Sutter, Tehama, Trinity, Tuolumne, Yolo, and Yuba – followed suit making primary care services available to undocumented Californians (Karlamangla, 2015a).

The number has increased slightly since so that that now 48 counties provide some coverage; for example, Sacramento County recently joined the list of counties offering health services to undocumented residents on a sliding scale basis. The expansion of county programs marks a significant shift from the increasing restrictions that occurred after the last recession. The changes in policy may be due in part to both declining numbers of total insured residents resulting from the ACA that has lowered the demand for county-funded health care and improved economic conditions in the counties. However, there are several counties with large unauthorized populations (including San Joaquin, Stanislaus, Merced, San Luis Obispo, Santa Barbara, Orange, San Diego, San Bernardino, and Tulare Counties) that have not joined the expansion bandwagon.

Shifts in healthcare funding priorities may endanger the patchwork of safety net care for undocumented immigrants as the ACA implementation continues across the state. Expecting decreased demand for indigent health programs as more Californians obtain coverage through Medi-Cal or Covered California, state funds have been cut that would otherwise have gone to support counties' health services budgets (Karlamangla, 2014a). Fortunately, those needing county services are fewer: As of July 2015, all California children, regardless of status, became eligible for medical coverage (Megerian, 2015; Wright & Health Access, 2015). Still, many undocumented adults remain without eligibility and as officials debate whom and what services to cover with local resources, there is always a temptation to drop eligibility.

Reliance on this patchwork approach for the remaining uninsured due to legal status is always tenuous. Consider, for example, the debate about indigent care in Fresno. At the end of 2013, county health officials were in a court battle to terminate a 1984 injunction requiring it to provide health care to undocumented immigrants (Anderson, 2014). The stakes were high, threatening to affect some 4,500 to 5,000 unauthorized and uninsured immigrants in Fresno. The county cited the $14 million cut in state funds for indigent care, set in motion by ACA implementation, as the primary reason for trying to eliminate services to unauthorized immigrants. Without access to county health programs, community clinics would be the only non-emergency option for undocumented immigrants – though the county could cut contracts with such clinics, leaving them strapped for funding. The County did win the suit and the Board of Supervisors voted to end the medically indigent program and cancelled its related contracts. But the community and statewide pushback was so strong that the County put a stay on scaling back programs (pending clarity on AB 85 reimbursements, which will provide funds for indigent health care programs to make up for previous cuts) and is looking to fill the funding gap (Health Access, 2015b). As of April 2015, the Supervisors in a 3-2 vote instated a temporary $5.6 million program that will end when state funding runs out (Anderson, 2015).

California's health care safety net for undocumented immigrants has been largely determined by the coverage and access options in each county's indigent care program given the high proportion of undocumented immigrants who are uninsured and low-income. In contrast to Fresno, for example, the Healthy Kids program run by the City and County of San Francisco uses local funding to provide coverage to all uninsured children under 19, regardless of immigration status, who do not qualify for other federal or state programs (Gusmano, 2012a). The 2015 Health Access report summarizes the patchwork nature of the state's safety net, but it also summarizes a moving target. Many of the cuts to services originating during the 2008 recession and ensuing budget cuts (e.g., Fresno, Sacramento, and Yolo counties) are now being restored (Health Access, 2015b).

The local approach clearly leaves gaps. As noted, ten counties remain that do not provide medical coverage to any of their undocumented residents: Merced, Orange, Placer, San Bernardino,

San Diego, San Joaquin, San Luis Obispo, Santa Barbara, Stanislaus, and Tulare (Karlamangla 2015). Localities can also lean in the other direction: since full implementation of the ACA and clarity around AB 85 implementation, Orange and San Luis Obispo counties implemented an asset and/or medical necessity requirement for use of their medically indigent programs, negatively impacting access to those programs. In contrast, Alameda, Los Angeles, Riverside, San Francisco, San Mateo, and Santa Clara have broad eligibility requirements around income and immigration status and still have thousands of Californians receiving care (Health Access, 2015b). Santa Clara County, for example, represents the achievement of a major milestone in the universal healthcare initiative with the approval for a model program to provide access to health coverage for all residents regardless of immigration status and income starting in January 2016 (Ma Lebron, 2015). This sort of patchwork approach means that some undocumented immigrants gain access while others are left out, raising the question of whether a more uniform approach could yield higher health benefits for the state.

A Model: Children's Health Initiatives (CHIs)

Could expanding access through both state and local mechanisms have noticeable impacts? A two-year demonstration project to achieve universal health insurance for undocumented children provides an important precedent and lessons for the state. Initially funded and led by a private foundation (The California Endowment), this project aimed to enroll and insure 7,500 undocumented children (Frates, Diringer, & Hoga, 2003). It also provided an opportunity to assess approaches to extending insurance to this population through different types of non-profit or quasi-public insurance programs. Five non-profit health plans from around the state were selected to be funded because of their existing infrastructure and capacity to quickly extend care to new enrollees. Overall, the initiative included a collaboration of more than thirty organizations that met regularly over the two years to share outreach and enrollment plans, discuss issues around extending insurance to immigrants, and support policy advocacy in this area.

Although the TCE project was discontinued when funding dried up, it made important contributions to informing best practices. The program quickly and successfully enrolled the target number of children, most of whom were Latino and from low-income and mixed legal status families. Outreach and enrollment activities were considered crucial to this success, and evaluation findings indicated that referrals from community-based organizations from programs such as the Migrant Education and Head Start were the most effective. The project also helped streamline the enrollment process by shortening required paperwork and offering it in parents' native language. Once children were enrolled, further outreach efforts encouraged families to use the services. Policy lessons were also gained from the project – it specifically became clear that it is important that commitment to contribute substantial resources and other forms of support comes from multi-disciplinary stakeholders, not a single foundation or health plan.

A number of other initiatives complemented the TCE-funded project. Children's Health Initiatives (CHIs) were started throughout the state in the early 2000s with the aim of providing insurance for low-income children who were not otherwise eligible for coverage. These were financed primarily through foundation and private donations, along with county funding, with the intent of establishing programs that the State would eventually provide funding for. Legislation to establish state funding was vetoed several times and the Great Recession ended attempts to secure state funds. Each county was different, but in general the plans provided comprehensive coverage for very low premiums (Stevens, Rice, & Cousineau, 2007). At their peak, there were 26 counties with programs covering more than 85,000 children. The recent inclusion of funding for AB 4, which would cover all low-income children in the state (see above), can be considered a return to this model.

An evaluation of these programs found that enrollees, compared to those on the wait list for coverage, were more likely to have a usual source of care and better medical home experiences, such as continuity and comprehensive care (Stevens et al., 2011). Demand for the CHI policies often exceeded available funding and most programs had to change due to declining financial support. First 5 continues to provide a major source of funding for insurance for children ages zero to 5, but other sources of support have declined, particularly for those 6 to 18 (Cousineau, Tsai, & Kahn, 2012). Kaiser Permanente continues to support a low or no premium health insurance policy for low-income children not otherwise eligible for coverage, as part of its community benefits program in counties where it has facilities. The number of enrollees is capped, however, at a relatively low number compared to the demand.

The California Health Care Foundation supports CaliforniaKids, a limited service insurance available in about one-third of California's counties – it does not include hospitalization and is available to low-income families not otherwise eligible for low-cost insurance. Although the program started out as premium-free or nearly free due to foundation and corporate donations, rising costs and declining donations led to increased premiums that cost $82 per child per month in 2014 (CaliforniaKids Healthcare Foundation, 2006; C. Coleman, 2014).

Closing Gaps in Coverage: Some Emerging Ideas for Policy

Researchers and health access advocates concur that the best way to close gaps in coverage for immigrants, particularly for undocumented individuals, is to make healthcare access a part of comprehensive immigration reform while protecting and expanding the healthcare safety net in the interim (Berlinger & Gusmano, 2013; R. Coleman, 2012; Foundation, 2013; Ponce, Lavarreda, & Cabezas, 2011; Wallace, Torres, Nobari, & Pourat, 2013a; Wallace, Torres, et al., 2013b). Despite this, the comprehensive immigration reform passed by the U.S. Senate in 2013 (only to be stalled in the House of Representatives) required a 10-year wait before applicants receive any public benefits. This suggests that even if reform goes forward issues regarding the lack of access to medical insurance will plague these populations, even if they have achieved some tentative legal status. [15]

[15] It seems less likely that immigration reform will pass in the near future given the political conflicts and stalled status of the proposed expansion of deferred action to the undocumented parents of U.S.-citizen children.

My Home, My Health: One LA-IAF's community organizing efforts to reform L.A. County's medical coverage for undocumented residents

My Health LA is Los Angeles County's most recent initiative designed to provide healthcare services to residents who are not eligible under the Affordable Care Act (ACA) and cannot afford to purchase their own health insurance – in practice, a program that covers undocumented residents. My Health L.A. replaced the Healthy Way L.A. "unmatched" program in an effort to improve efficiency and shift the focus of healthcare from emergency to preventative care. The new program was launched on October 1, 2014 with a budget of $61 million for the initial year.

My Health L.A. was shaped by the community to address some of the limitations of the earlier Healthy Way L.A. program that covered undocumented residents. To prevent wasteful spending and duplication of treatment – all the while encouraging continuous, preventative healthcare services – My Health L.A. now provides patients with a "medical home." Patients are assigned to one doctor where their care is coordinated through free primary care and health screenings, chronic disease management, prescription medications, referrals to specialty care at county facilities, and other services. Clinics are now paid $32 a month per patient instead of $94 per visit, to encourage doctors to keep patients healthy and avoid expensive treatments later – the healthier they keep the patients, the less funding they will need to use and the more funding they will get to keep.

The improved effectiveness and holistic approach is largely due to community organizing efforts facilitated by One LA-IAF, an organization that equips congregations, schools, nonprofits, and unionized labor for civic engagement to improve their communities. As One LA-IAF was helping with ACA enrollment, eligibility was a prominent concern expressed by the community. Additionally, undocumented community members were apprehensive when seeking healthcare eligibility information and frustrated by the typical eight-hour wait time, which often ended in learning they lacked proper documentation and would have to return for a second visit. One LA-IAF relayed these concerns and a desire for partnership to the L.A. County Department of Health Services (DHS) but progress in expanding coverage was slow.

So One LA-IAF relied on good old-fashioned organizing to get its message across: it rallied over 500 people to communicate their concerns to the L.A. County Board of Supervisors. After continued efforts, One LA-IAF gained a seat at the table with DHS Director, Dr. Mitchell Katz, and other stakeholders involved in the design of My Health L.A. According to a One LA-IAF organizer, when the program was implemented, One LA-IAF was invited to become the first community partner with access to the DHS system in order to assist with enrollment services. Such practical steps to improve the program have contributed to, as of April 2015, over 100,000 residents enrolling.

However, an analysis a year after its implementation found that the county fell about 11,000 short of the enrollment target of 146,000, and left $20 million of the budget unspent. Recommendations to improve enrollment rates include expanding sign up locations from only community health centers, to mobile clinics, health fairs, and other more accessible locations like grocery stores and laundromats. A proposal to increase income eligibility to those making 150% of the federal poverty level or higher to increase enrollment is also being considered.

Sources: E. Chavez, 2015; Florido, 2015a, 2015b; One LA-IAF, 2015.

At the federal policy level, the Health Access Foundation recommends that the ACA provisions be revised to include coverage for individuals regardless of immigration status (Foundation, 2013). An alternative in the interim would be to extend coverage options to those with provisional legal status, such as DACA; this has been done in California where DACA recipients are eligible for state-funded Medi-Cal (CIPC, 2014). Such an action may be more politically popular than is usually believed. For example, polls show that almost three-quarters of Americans believe that undocumented residents should have a way to remain legally in the country (Doherty, Tyson, & Weisel, 2015). Earlier research found that 63 percent of Americans believed undocumented immigrants with provisional status should have access to Medicaid and 59 percent believed they should have access to insurance subsidies under the ACA; these numbers include 40 percent of Republicans on both counts (Mukherjee, 2013).

To protect safety net programs, the Hastings Center specifically recommends that federal Health and Human Services funds for such services be directed to states with large informal labor markets where undocumented and other low-income immigrants are likely to reside (Berlinger & Gusmano, 2013). State and local policy could also play a large role in expansion of coverage and in protecting access to services for undocumented immigrants through the creation of funding streams to support insurance coverage (Berlinger & Gusmano, 2013; R. Coleman, 2012; Foundation, 2013; Ponce et al., 2011; Wallace, Torres, et al., 2013b).[16]

A 2015 report by University of California researchers examined laws and regulations affecting the health of undocumented immigrants in states across the U.S. They recommend the following areas for public policy changes that would impact the health of undocumented immigrants in the long run:

1. A wider variety of social welfare policies that provide basic rights;

2. Policies specific to health issues (e.g., end-of-life care) and labor issues (e.g., preventing wage theft or occupational injury, etc.);

3. Administrative and implementation policies at the state and local levels that promote immigrant integration, such as free ESL classes, legal assistance in seeking deferred action or other options for obtaining lawful status, and professional licenses without regard to immigration status;

4. Policies that create a climate of acceptance of all immigrants and that would reduce immigrants' fear and avoidance of public authorities (Rodríguez, Young, & Wallace, 2015, p. 2).

California has begun to make progress on these issues. Medi-Cal expansion to undocumented children is an important first step that will be implemented in 2016 and it sets the stage for possible further expansion to adults. Some suggest that any extra costs to the state are justified not only for the health rationales offered above but also because undocumented immigrants in California pay $2.7 billion annually in sales, income and property taxes (Castrejon et al., 2013; R. Coleman, 2012).[17]

[16] In addition, some advocates suggest that the United States institute a bi-national health program with Mexico in border states to better care for Mexican immigrants (Castrejon et al., 2013; Wallace, Torres, et al., 2013b).

[17] For estimated increases in Medi-Cal enrollment by undocumented Californians and costs to the state, see Lucia et al. (2014).

However, even extending insurance is not enough to insure coverage. Consistent with the discussion above on the many reasons why immigrants may not take up insurance and other services, the literature reveals that outreach is as important as inclusion in eligibility rules and funding for services. A study done for the Department of Health and Human Services recommends that agencies: (1) contract partnerships with community-based organizations (CBOs) to help eligible immigrant families feel more comfortable in accessing services, (2) simplify application procedures, including accepting simple forms of paperwork and minimizing requirements for information from family members not applying for coverage, and (3) remove language and logistical barriers (Crosnoe et al., 2012; Kaiser Family Foundation, 2013b). The experience of programs that have helped all persons sign up for ACA marketplace policies has suggested that many newly insured have questions about how to use their insurance; improving limited health literacy is likely to be the next major need after enrollment in insurance (Pollitz, Tolbert, & Ma, 2014; Long, et al., 2013).

CONCLUSION

The image of undocumented Californians held by many members of the public is often quite removed from reality. Rather than being recently arrived, the median number of years in the country for the undocumented is a full decade. Rather than being unattached individuals, undocumented residents form families – and nearly one-fifth of the state's children have at least one undocumented parent. And rather than being sojourners who simply slip back and forth, undocumented residents seem to have become a deeply embedded part of our workforce and neighborhoods.

This important and mostly permanent nature of undocumented Californians is certainly the case in the BHC sites being supported by TCE. In these communities – which TCE considers to be model sites for improving the social determinants of health – the share of residents who are unauthorized is more than twice that of the rest of the state. These residents can experience lower socioeconomic and health outcomes as a result of tenuous legal status – but the effects are not limited to them since there are ripple effects for their children, employers, and communities.

Providing both medical insurance and adequate health care for all Californians is a goal many share for moral or political reasons. We share those normative beliefs but we also think that it simply makes good policy in terms of the long-term future of the state. For while many remain stuck in past paradigms and express concern that immigration is on the rise, the reality is that the share of foreign-born in California is on the decline. When we look around the Golden State, we essentially see the population we will be living with into the future, partly because it is difficult to conceive that the federal government will (despite some current political rhetoric) launch a massive deportation campaign. As a result, providing access to both medical insurance and decent health care to all the state's residents will improve both health and economic outcomes for those currently uninsured as well as for the larger labor market and society as a whole.

Moreover, the nation's changing demographics, the likely impact of those demographic changes on politics, and the current relative popularity of comprehensive immigration reform in polls (including among Republicans) all combine to suggest the current undocumented population will eventually find their way to some sort of legal status. That means that places like California face a stark choice: Do we want to eventually bring into the fold a population that has been left out of the health care system or do we want to get ahead of the game and extend health insurance soon and more completely so that the group has the best possible health when they gain legal status?

We think that looking forward is a better strategy. As we have shown in this report, barring the remaining ineligible undocumented Californians from medical insurance will hinder individual and public health, economic well-being, and the resilience of the state. Fortunately, even as current national policy design explicitly excludes undocumented immigrants from gaining access to insurance coverage under the ACA's provisions, California has chosen to move ahead with an effort that will in 2016 allow undocumented children in California to be eligible for Medi-Cal and may, in the future, open a path for their parents as well.

Photo by Elvert Barnes

This path forward has not simply been a choice by wise policy makers, although they have surely played a role. In addition, advocates for both health access and immigrant integration – including many in the fourteen BHC communities – have come together to support a campaign called "Health4All." The program they are pushing suggests that California should likely go beyond extending Medi-Cal and also allow for a parallel program so that undocumented immigrants who lack employer insurance and are not poor enough to qualify for Medi-Cal can purchase insurance with benefits and support similar to those buying insurance through Covered California, our state exchange.

While this sort of approach is essentially a stopgap for what is a national problem and a national shortcoming, such state and local efforts can both make a difference now and point the way toward possible alternatives. Insurance alone will not generate health and even if insurance is extended, immigrants face challenges navigating medical bureaucracies, language barriers, and unfamiliarity with U.S. systems. But accessing medical insurance is a first step toward closing health gaps that affect populations now and will limit our possibilities for the future.

Ultimately, questions about both immigration and insurance boil down to the fundamentals of vision and values: who are we as Americans and Californians and who is inside and outside what we consider to be our community? There are no easy answers to these challenging questions but we hope that the research we have offered here about the size and importance of the undocumented population, and about how extending medical insurance could benefit both immigrants and the state, can at least set the grounds for a more productive conversation about health policies in the Golden State.

Appendix A: Estimating the Unauthorized Population

Estimating the unauthorized or undocumented population is, of course, the first step to calculating the incidence of health insurance for that population. In this exercise, we adopted an increasingly common strategy (Capps et al., 2013; Warren, 2014) that involves two steps. The first involves determining who among the non-citizen population is least likely to be undocumented due to a series of conditions which are strongly associated with documented status (a process called "logical edits"). The second involves sorting the remainder into documented and undocumented, based on a series of probability estimates (applied to reflect the underlying distribution of probabilities.) The specific technique below was applied to a pooled 2008-12 pooled version of the ACS; the actual data used came from IPUMS-USA (Ruggles, Genadek, Goeken, Grover, & Sobek, 2010).

We start the estimation process by assuming that the aggregate total of undocumented adults in the U.S. in 2012 (what we hoped our sample simulated) was similar to that reported in the most recent estimate from the Office of Immigration Statistics (Rytina, 2013) or by the Migration Policy Institute (Capps et al. 2013). In the first "logical edit" step, we take every non-citizen, foreign-born respondent (with the exception of Cubans who are automatically granted legal status upon arrival to the U.S.) in our pooled ACS sample and assign to each an initial documentation status based on certain characteristics. For example, we assumed that any non-citizen, non-Cuban immigrant with military experience must be a Lawful Permanent Resident (LPR). Other characteristics that led us to tag a respondent into LPR status included whether or not the respondent worked for the public sector; had an occupation (such as police officer) that required documentation; received social security or disability payments; or was a household head or spouse in a household receiving food stamps, but did not have a child in the house (who could have been the legal source of the assistance). We assumed that those who immigrated as adults and were currently enrolled in higher education were likely student visa holders, and not among the undocumented population. We assumed, as do others [for example, (Warren, 2014)], that any immigrant who arrived before 1982 reached legal status through the Immigration Reform and Control Act of 1986. Finally, we placed respondents in the LPR category if they received Medicare, Veterans Affair Care, or Indian Health Services.[18]

That initial assignment leaves us with an undocumented population that is significantly larger than it should be, according to estimates by OIS and others; that is, that logical edits are not enough to sort out the documented from the undocumented, and so the remainder of the population still needs to be sorted into LPR and undocumented categories. To assign the rest, we first determined the probability of being undocumented using a technique similar to that in Capps, et al. (2013). Following the very clear directions kindly provided by those authors, we started with Wave 2 of the most recent available Survey of Income and Program Participation (SIPP) from 2008, in which respondents offered answers with regard to whether they had LPR status upon arrival and whether they had ever

[18] We did not assume that reporting Medicaid was sufficient to designate one as documented (as does Warren (2014) for men older than 19 and for women also older than 19 who have not had a child in the last year). However, in California, previous research does suggest that there are users of such services who are undocumented (Marcelli & Pastor, 2015); moreover, the ACS question about Medicaid is ambiguous and could be answered in the affirmative by undocumented residents using other government services such as community clinics and county-based support.

achieved it later; those who answered "no" to both were considered to be undocumented.

In our estimation of the probabilities, we reduced that sample of immigrants in two ways. To understand why, it is important to realize the purpose at hand: to take the estimates of the impact of various variables on the probability of being undocumented, and apply those to data in the ACS. But recall that the sample to which we apply the estimates is a sample created *after* logical edits that have excluded all pre-1982 immigrants and all those who are likely on student visas. Thus, we first drop from the SIPP sample the same potential individuals, slicing the sample down to those who arrived after 1980 (because that is the break in the SIPP coding) and removing all foreign-born residents who arrived in the last five years who are currently enrolled in undergraduate university or graduate school.[19]

Next we utilize a logistic regression strategy in which the probability of being undocumented is determined by an equation in which the right-hand side variables include gender, age, years since arrival, education levels, marital status (whether never married and if married, whether married to a U.S.-born or naturalized citizen), English ability, and several dummy variables for broad region; this specification is similar to and based on the discussion in (Hook et al., 2015). Finally we apply the coefficients from that regression – basically the probability that an individual could be unauthorized – to the observations in the pooled ACS data.

With probabilities assigned to our ACS pooled data, the next step in the process is to utilize "country controls" as in Warren (2014) to get a better fit. Country controls essentially mean adjusting the number of undocumented immigrants in each country-of-origin to fit the total number of unauthorized immigrants from a given country that most observers believe to be the case. We take advantage of the fact that the Office of Immigration Statistics offers a breakdown of the top 10 nations of origin of the undocumented (Rytina, 2013).[20] For the remaining countries, we used a variety of approaches. For example, we utilized two-year averages from 2009 and 2010 for the Brazilian undocumented (their official numbers fell in recent years and so the count was not in the most recent OIS reports on the top ten); other studies have shown that unauthorized Brazilians are a very large share of the non-citizen Brazilian immigrant population (Marcelli et al., 2009). At the end of the targeting and assignment process, we have a total number of adult undocumented residents that is close to the OIS totals.[21]

More precisely, the totals we utilize are close to the OIS numbers, assuming a degree of undercount. There is a widely shared assumption that the undocumented are undercounted by around 10 percent in the decennial census (Marcelli & Ong, 2002), and more in other samples. Warren and Warren 2013 contend that the undercount might be as high as 20 percent in recent years because the ACS is perceived as a more voluntary survey by respondents than is the Census. We settled on an undercount estimate of 12.5 percent, which recognizes that 10 percent is likely too low, but also recognizes that 20 percent is likely too high.[22] To account for the undercount,

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[19] Capps, et al. (2013) use a similar approach to determining who in the SIPP is undocumented. They then essentially add these individuals to the American Community Survey (ACS) and use a multiple imputation strategy to populate "missing" answers for the ACS (which are basically all the answers).

[20] Warren (2014) develops an independent estimate of these country totals.

[21] We investigated the next 20 largest countries sending immigrants, taking advantage of several bits of knowledge in the field, including an estimate of undocumented Canadians that was generated by the Migration Policy Institute (MPI) in 2008 and other work that suggests that the share of undocumented is surprisingly low in the Dominican community (Marcelli et al., 2009). For other countries, we use available information on similar countries in their hemisphere (either from the overall data or from the information in the SIPP data) to target a percent undocumented and hence number undocumented.

[22] Using a 12.5 percent undercount also brings our implicit observations for LPRs in line with the nation-by-nation OIS totals for that population, especially LPRs eligible to naturalize (Pastor, Oakland, & Sanchez, 2014; Rytina, 2013).

we initially set the targets below the target adult numbers (nation-by-nation) so that when we reweighted all of those observations up with the undercount factor, we would arrive at the correct total number.

From the pool of remaining individuals (people not identified as LPRs during the logical edits), we then assign individuals in the ACS to having either documented or undocumented status, until we reach the country controls. However, the process is slightly more complicated than what might be one's first guess: if we then sort those individuals by the probability of being undocumented and select the most likely, we could wind up with a population falsely skewed younger and more male than the actual population. Thus, we adopt an approach that is similar in spirit to multiple imputation (James D. Bachmeier, Van Hook, & Bean, 2014; Batalova, Hooker, & Capps, 2014).

Specifically, we round the probabilities to the second decimal and sort the unauthorized into just over 60 possible groups of individuals who share the same probability of being undocumented. We then mimic the underlying probability distribution of the undocumented from each country by stratifying each county sample into twenty strands, and then successively pull from each of the strands to reflect the country's underlying distribution of probabilities. To understand the logic, consider a country with only three probability groups: one with a 50 percent probability of being undocumented, a second with a 25 percent probability of being undocumented, and a third with a 10 percent probability. In the first strand, we chose fifty percent from the first group, then twenty-five percent from the next group, and ten percent from the third group, and designate them as undocumented. We then move to the second strand and repeat that process, continuing through the strands until we hit the country controls; the resulting sample gets close to the underlying population probabilities. Because this process corrects for the bias of sorting simply by high probability, it more or less simulates a multiple imputation procedure and so it is no surprise that our numbers and our population characteristics are relatively close to those of MPI.

With individual adults tagged as undocumented, we turn to youth, assigning minor children as undocumented if at least one of his/her parents is undocumented (and the other is either undocumented, LPR or not present). After adding that number to the adult count, we make some minor adjustments to weights by state in order to better fit our data to state totals also available from the Office of Immigration Statistics. We ultimately come up with a total of 11,391,000 undocumented immigrants – a bit below the 11,400,000 estimated by MPI in 2014 and the 11,430,000 estimated by the Office of Immigration Statistics for 2012.

Assigning households to the BHC sites is another challenge. Each individual in the ACS is tagged by the Public Use Microdata Area (or PUMA) in which they reside. Unfortunately, PUMAs and BHC sites are not the same (although PUMAs generally exist within counties, something that makes county totals easier to derive). To assign individuals to BHC sites, we first utilize data from Mable/GeoCorr that essentially uses GIS techniques to intersect PUMAs with the underlying block group; we can use that data to determine what percentage of a PUMA's population lies within a BHC site. We then pulled enough households from each PUMA (or PUMAs) to meet the population total.

The shortfall with this simple approach – one that we took in an earlier iteration of this analysis in fact sheets we released on the BHC sites in early 2015 (see http://dornsife.usc.edu/csii/unauthorized-and-uninsured) – is that it does not necessarily wind up matching the characteristics of the BHC population that can be surmised by adding up tract-level data. For example, in one simple case, the Boyle Heights BHC lies entirely within one PUMA. However, it is only part of that PUMA and the BHC neighborhood is much more Latino than the overall PUMA. To correct for that, for all BHC sites, we pulled more individuals than necessary (but in the correct proportions from multiple PUMAs) and then did a two-step iterative

proportional fit to arrive at an ethnic distribution similar to that that could be calculated from tract-level summary characteristics. We then adjusted to fit overall and ethnic-specific poverty rates, again, using a two-step approach. While the final numbers are not exactly what a tract-level summary would give you in terms of other socioeconomic characteristics – such as percent foreign-born – they are very close and much better than a simple pull by population from the PUMAs.

Both because we utilized a SIPP-based approach to generate the estimates of the undocumented and because we deploy an improved new approach to "fitting" the microdata to neighborhoods, the numbers in this report do not exactly match those in the fact sheets released in early 2015, particularly at the neighborhood level where the new geographic process is employed.

APPENDIX B: PROFILES OF THE BHC SITES

The following pages contain profiles for 14 Building Health Communities Sites

City Heights
East Coachella Valley
Central Santa Ana
Central West Long Beach
South Los Angeles
Boyle Heights
Del Norte County
South Sacramento
Richmond
East Oakland
Southwest and East Merced
Central, Southeast, and Southwest Fresno
East Salinas
South Kern

2008-2012 Population Profile: Building Healthy Communities City Heights

TOTAL POPULATION	84,396	
Race and Ethnicity		
Non-Hispanic White	10,067	12%
Latino	46,238	55%
Asian or Pacific Islander	15,292	18%
Black	10,730	13%
Other	2,069	2%
Nativity and Legal Status		
U.S.-born (U.S. Citizen)	50,842	60%
Foreign-born ("Immigrant")	33,554	40%
Naturalized Immigrant (U.S. Citizen)	12,492	15%
Authorized Immigrant (Non-U.S. Citizen)	9,528	11%
Unauthorized Immigrant (Non-U.S. Citizen)	11,534	14%
Speaks English Well (among Those Age ≥ 5 Years Old) [1]	62,606	81%
Immigrant	19,422	58%
Naturalized Immigrant	8,497	68%
Authorized Immigrant	5,786	61%
Unauthorized Immigrant	5,139	45%
Poverty (Family Income < 150% of Poverty Line) [2]	35,183	42%
U.S.-born	20,393	40%
Immigrant	14,790	44%
Naturalized Immigrant	4,386	35%
Authorized Immigrant	4,470	47%
Unauthorized Immigrant	5,934	51%
Homeownership	7,859	29%
U.S.-born	4,190	32%
Immigrant	3,669	27%
Naturalized Immigrant	2,740	42%
Authorized Immigrant	560	17%
Unauthorized Immigrant	369	10%

INSURANCE/COVERAGE FOR WORKING AGE POPULATION (25-64)		
Has Medical Insurance Coverage	26,781	63%
U.S.-born	14,306	78%
Immigrant	12,475	52%
Naturalized Immigrant	6,382	71%
Authorized Immigrant	3,093	48%
Unauthorized Immigrant	3,000	35%
Has Employer-Sponsored Medical Insurance Coverage	17,095	40%
U.S.-born	9,897	54%
Immigrant	7,198	30%
Naturalized Immigrant	4,040	45%
Authorized Immigrant	1,693	26%
Unauthorized Immigrant	1,465	17%
Has Low-Income Government Insurance or Assistance (e.g., Medi-Cal) [3]	6,268	15%
U.S.-born	2,347	13%
Immigrant	3,921	16%
Naturalized Immigrant	1,536	17%
Authorized Immigrant	1,080	17%
Unauthorized Immigrant	1,305	15%

CHILD POPULATION (< 18 YEARS OLD)	23,747	
Nativity and Legal Status		
U.S.-born	20,785	88%
Immigrant	2,962	12%
Unauthorized Immigrant	1,212	5%
Resides with at Least One Immigrant Parent [4]	16,317	69%
of those children, share US-born	13,612	83%
Resides with at Least One Unauthorized Immigrant Parent [4]	7,471	31%
of those children, share US-born	6,032	81%
Child Poverty (Family Income < 150% of Poverty Line) [4]	13,289	56%
Resides with ≥ 1 U.S.-born Parent	4,013	49%
Resides with ≥ 1 Immigrant Parent	9,821	60%
Resides with ≥ 1 Naturalized Parent	2,957	50%
Resides with ≥ 1 Authorized Immigrant Parent	3,582	59%
Resides with ≥ 1 Unauthorized Immigrant Parent	5,151	69%

UNAUTHORIZED IMMIGRANT POPULATION		
Places of origin		
Mexico	8,776	76%
Central America	516	4%
Asia	1,897	16%
Rest of the World	346	3%
Female	5,829	51%
Age and Time in Country (Medians)		
Age	34 years	
Age First Arrived in Country	21 years	
Years Residing in the USA	10 years	
Labor Force Participation (Age 18-64 Years Old)	6,960	68%
Male Participation	4,385	88%
of which, share employed	4,122	94%
of employed, share full-time	2,901	70%
Female Participation	2,575	49%
of which, share employed	2,335	91%
of employed, share full-time	1,215	52%
Top 5 Industries	4,591	82%
Retail Trade	1,673	30%
Construction	998	18%
Business and Repair Services	750	13%
Personal Services	699	12%
Agriculture, Foresting, Fishing and Hunting	471	8%
Top 5 Occupations	3,924	70%
Food Preparation and Service Occupations	1,173	21%
Cleaning, Building and Household Service Occupations	1,135	20%
Construction Trades	641	11%
Helpers in Construction and Freight Handlers	493	9%
Farming, Forestry, and Fishing Occupations	482	9%

Methodology

The results in this fact sheet are based on a three-step method the USC Center for the Study of Immigrant Integration (CSII) uses to estimate the undocumented. Starting with the pooled 2008-2012 American Community Survey (ACS) Public Use Microdata Sample data, the first step involves determining who among the non-citizen population is highly unlikely to be undocumented based on certain characteristics. The second step calculates the probability of being undocumented for the remaining non-citizen population by applying coefficients based on a regression analysis of data from the 2008 Survey of Income and Program Participation. The third step then utilizes these strict cut-offs and probability estimates to fit the ACS microdata to national aggregate estimates for the undocumented by country of origin.

Notes

(-) indicates that the underlying number of observations is too small to make a reliable calculation of the variable in question.

[1] Virtually all U.S.-born respondents in the ACS either report speaking English very well or speak no other language but English at home.

[2] These are computed at the individual level using the ACS variable indicating the ratio of family income to the poverty line by family type.

[3] Employer and low-income insurance coverage do not add up to total coverage which also includes private purchased insurance, veteran coverage, etc.

[4] The denominator is the number of children residing with at least one parent.

2008-2012 Population Profile: Building Healthy Communities Eastern Coachella Valley

TOTAL POPULATION	34,618	
Race and Ethnicity		
Non-Hispanic White	675	2%
Latino	33,471	97%
Asian or Pacific Islander	113	0%
Black	198	1%
Other	162	0%
Nativity and Legal Status		
U.S.-born (U.S. Citizen)	19,986	58%
Foreign-born ("Immigrant")	14,632	42%
Naturalized Immigrant (U.S. Citizen)	4,005	12%
Authorized Immigrant (Non-U.S. Citizen)	4,008	12%
Unauthorized Immigrant (Non-U.S. Citizen)	6,619	19%
Speaks English Well (among Those Age ≥ 5 Years Old) [1]	21,304	70%
Immigrant	6,411	44%
Naturalized Immigrant	2,473	62%
Authorized Immigrant	1,527	38%
Unauthorized Immigrant	2,411	37%
Poverty (Family Income < 150% of Poverty Line) [2]	16,605	48%
U.S.-born	8,745	44%
Immigrant	7,860	54%
Naturalized Immigrant	1,387	35%
Authorized Immigrant	2,061	51%
Unauthorized Immigrant	4,412	67%
Homeownership	4,822	53%
U.S.-born	2,038	58%
Immigrant	2,784	50%
Naturalized Immigrant	1,346	66%
Authorized Immigrant	696	47%
Unauthorized Immigrant	742	37%
INSURANCE/COVERAGE FOR WORKING AGE POPULATION (25-64)		
Has Medical Insurance Coverage	7,641	49%
U.S.-born	3,460	71%
Immigrant	4,181	39%
Naturalized Immigrant	1,688	56%
Authorized Immigrant	1,369	45%
Unauthorized Immigrant	1,124	25%
Has Employer-Sponsored Medical Insurance Coverage	5,323	34%
U.S.-born	2,680	55%
Immigrant	2,643	25%
Naturalized Immigrant	1,278	42%
Authorized Immigrant	806	26%
Unauthorized Immigrant	559	12%
Has Low-Income Government Insurance or Assistance (e.g., Medi-Cal) [3]	2,151	14%
U.S.-born	699	14%
Immigrant	1,452	14%
Naturalized Immigrant	406	13%
Authorized Immigrant	476	16%
Unauthorized Immigrant	570	13%

CHILD POPULATION (< 18 YEARS OLD)	12,939	
Nativity and Legal Status		
U.S.-born	11,407	88%
Immigrant	1,532	12%
Unauthorized Immigrant	933	7%
Resides with at Least One Immigrant Parent [4]	9,447	73%
of those children, share US-born	8,109	86%
Resides with at Least One Unauthorized Immigrant Parent [4]	6,179	48%
of those children, share US-born	5,156	83%
Child Poverty (Family Income < 150% of Poverty Line) [4]	7,366	57%
Resides with ≥ 1 U.S.-born Parent	1,676	39%
Resides with ≥ 1 Immigrant Parent	5,888	62%
Resides with ≥ 1 Naturalized Parent	1,053	41%
Resides with ≥ 1 Authorized Immigrant Parent	1,660	52%
Resides with ≥ 1 Unauthorized Immigrant Parent	4,161	67%
UNAUTHORIZED IMMIGRANT POPULATION		
Places of origin		
Mexico	6,183	93%
Central America	341	5%
Asia	96	1%
Rest of the World	-	0%
Female	3,187	48%
Age and Time in Country (Medians)		
Age	30 years	
Age First Arrived in Country	19 years	
Years Residing in the USA	9 years	
Labor Force Participation (Age 18-64 Years Old)	4,259	75%
Male Participation	2,692	93%
of which, share employed	2,227	83%
of employed, share full-time	1,370	62%
Female Participation	1,567	56%
of which, share employed	1,007	64%
of employed, share full-time	434	43%
Top 5 Industries	2,379	89%
Agriculture, Foresting, Fishing and Hunting	1,147	43%
Construction	486	18%
Retail Trade	415	16%
Personal Services	245	9%
Business and Repair Services	86	3%
Top 5 Occupations	2,228	84%
Farming, Forestry, and Fishing Occupations	1,117	42%
Food Preparation and Service Occupations	376	14%
Helpers in Construction and Freight Handlers	263	10%
Cleaning, Building and Household Service Occupations	247	9%
Construction Trades	225	8%

Methodology

The results in this fact sheet are based on a three-step method the USC Center for the Study of Immigrant Integration (CSII) uses to estimate the undocumented. Starting with the pooled 2008-2012 American Community Survey (ACS) Public Use Microdata Sample data, the first step involves determining who among the non-citizen population is highly unlikely to be undocumented based on certain characteristics. The second step calculates the probability of being undocumented for the remaining non-citizen population by applying coefficients based on a regression analysis of data from the 2008 Survey of Income and Program Participation. The third step then utilizes these strict cut-offs and probability estimates to fit the ACS microdata to national aggregate estimates for the undocumented by country of origin.

Notes

(-) indicates that the underlying number of observations is too small to make a reliable calculation of the variable in question.

[1] Virtually all U.S.-born respondents in the ACS either report speaking English very well or speak no other language but English at home.

[2] These are computed at the individual level using the ACS variable indicating the ratio of family income to the poverty line by family type.

[3] Employer and low-income insurance coverage do not add up to total coverage which also includes private purchased insurance, veteran coverage, etc.

[4] The denominator is the number of children residing with at least one parent.

2008-2012 Population Profile: Building Healthy Communities Central Santa Ana

TOTAL POPULATION	78,635	
Race and Ethnicity		
Non-Hispanic White	1,781	2%
Latino	73,616	94%
Asian or Pacific Islander	2,316	3%
Black	523	1%
Other	399	1%
Nativity and Legal Status		
U.S.-born (U.S. Citizen)	38,007	48%
Foreign-born ("Immigrant")	40,628	52%
Naturalized Immigrant (U.S. Citizen)	8,945	11%
Authorized Immigrant (Non-U.S. Citizen)	10,508	13%
Unauthorized Immigrant (Non-U.S. Citizen)	21,175	27%
Speaks English Well (among Those Age ≥ 5 Years Old) [1]	48,438	68%
Immigrant	19,368	48%
Naturalized Immigrant	6,217	70%
Authorized Immigrant	5,177	50%
Unauthorized Immigrant	7,974	38%
Poverty (Family Income < 150% of Poverty Line) [2]	30,023	38%
U.S.-born	14,421	38%
Immigrant	15,602	38%
Naturalized Immigrant	2,128	24%
Authorized Immigrant	4,042	38%
Unauthorized Immigrant	9,432	45%
Homeownership	6,623	44%
U.S.-born	2,000	59%
Immigrant	4,623	39%
Naturalized Immigrant	2,454	63%
Authorized Immigrant	1,183	38%
Unauthorized Immigrant	986	21%

INSURANCE/COVERAGE FOR WORKING AGE POPULATION (25-64)		
Has Medical Insurance Coverage	20,064	52%
U.S.-born	5,119	70%
Immigrant	14,945	48%
Naturalized Immigrant	5,098	69%
Authorized Immigrant	3,846	48%
Unauthorized Immigrant	6,001	38%
Has Employer-Sponsored Medical Insurance Coverage	15,525	40%
U.S.-born	3,977	54%
Immigrant	11,548	37%
Naturalized Immigrant	4,378	59%
Authorized Immigrant	2,943	36%
Unauthorized Immigrant	4,227	27%
Has Low-Income Government Insurance or Assistance (e.g., Medi-Cal) [3]	3,733	10%
U.S.-born	828	11%
Immigrant	2,905	9%
Naturalized Immigrant	542	7%
Authorized Immigrant	790	10%
Unauthorized Immigrant	1,573	10%

CHILD POPULATION (< 18 YEARS OLD)	27,075	
Nativity and Legal Status		
U.S.-born	23,957	88%
Immigrant	3,118	12%
Unauthorized Immigrant	1,983	7%
Resides with at Least One Immigrant Parent [4]	21,864	81%
of those children, share US-born	19,048	87%
Resides with at Least One Unauthorized Immigrant Parent [4]	13,572	50%
of those children, share US-born	11,485	85%
Child Poverty (Family Income < 150% of Poverty Line) [4]	12,487	46%
Resides with ≥ 1 U.S.-born Parent	1,806	32%
Resides with ≥ 1 Immigrant Parent	10,286	47%
Resides with ≥ 1 Naturalized Parent	1,668	31%
Resides with ≥ 1 Authorized Immigrant Parent	3,410	41%
Resides with ≥ 1 Unauthorized Immigrant Parent	7,113	52%

UNAUTHORIZED IMMIGRANT POPULATION		
Places of origin		
Mexico	19,971	94%
Central America	1,046	5%
Asia	62	0%
Rest of the World	96	0%
Female	9,961	47%
Age and Time in Country (Medians)		
Age	32 years	
Age First Arrived in Country	19 years	
Years Residing in the USA	11 years	
Labor Force Participation (Age 18-64 Years Old)	14,617	77%
Male Participation	9,463	94%
of which, share employed	8,712	92%
of employed, share full-time	5,913	68%
Female Participation	5,154	57%
of which, share employed	4,409	86%
of employed, share full-time	2,557	58%
Top 5 Industries	9,118	78%
Manufacturing	2,378	21%
Retail Trade	2,251	20%
Business and Repair Services	1,773	16%
Agriculture, Foresting, Fishing and Hunting	1,419	12%
Construction	1,297	11%
Top 5 OccupatIons	4,432	73%
Farming, Forestry, and Fishing Occupations	2,328	39%
Helpers in Construction and Freight Handlers	618	10%
Cleaning, Building and Household Service Occupations	570	9%
Construction Trades	467	8%
Food Preparation and Service Occupations	449	7%

Methodology

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Notes

(-) indicates that the underlying number of observations is too small to make a reliable calculation of the variable in question.

[1] Virtually all U.S.-born respondents in the ACS either report speaking English very well or speak no other language but English at home.

[2] These are computed at the individual level using the ACS variable indicating the ratio of family income to the poverty line by family type.

[3] Employer and low-income insurance coverage do not add up to total coverage which also includes private purchased insurance, veteran coverage, etc.

[4] The denominator is the number of children residing with at least one parent.

2008-2012 Population Profile: Building Healthy Communities Central West Long Beach

TOTAL POPULATION	84,638	
Race and Ethnicity		
Non-Hispanic White	5,173	6%
Latino	52,786	62%
Asian or Pacific Islander	13,551	16%
Black	11,284	13%
Other	1,846	2%
Nativity and Legal Status		
U.S.-born (U.S. Citizen)	52,426	62%
Foreign-born ("Immigrant")	32,212	38%
Naturalized Immigrant (U.S. Citizen)	9,138	11%
Authorized Immigrant (Non-U.S. Citizen)	8,627	10%
Unauthorized Immigrant (Non-U.S. Citizen)	14,447	17%
Speaks English Well (among Those Age ≥ 5 Years Old) [1]	61,227	79%
Immigrant	16,697	52%
Naturalized Immigrant	6,716	74%
Authorized Immigrant	4,517	52%
Unauthorized Immigrant	5,464	38%
Poverty (Family Income < 150% of Poverty Line) [2]	40,163	49%
U.S.-born	25,540	49%
Immigrant	14,623	45%
Naturalized Immigrant	3,085	34%
Authorized Immigrant	4,201	49%
Unauthorized Immigrant	7,337	51%
Homeownership	5,015	19%
U.S.-born	2,545	19%
Immigrant	2,470	19%
Naturalized Immigrant	1,563	33%
Authorized Immigrant	534	15%
Unauthorized Immigrant	373	8%

INSURANCE/COVERAGE FOR WORKING AGE POPULATION (25-64)		
Has Medical Insurance Coverage	28,041	64%
U.S.-born	14,772	78%
Immigrant	13,269	53%
Naturalized Immigrant	5,250	76%
Authorized Immigrant	3,535	54%
Unauthorized Immigrant	4,484	39%
Has Employer-Sponsored Medical Insurance Coverage	15,272	35%
U.S.-born	8,735	46%
Immigrant	6,537	26%
Naturalized Immigrant	2,982	43%
Authorized Immigrant	1,599	24%
Unauthorized Immigrant	1,956	17%
Has Low-Income Government Insurance or Assistance (e.g., Medi-Cal) [3]	10,486	24%
U.S.-born	4,510	24%
Immigrant	5,976	24%
Naturalized Immigrant	1,702	25%
Authorized Immigrant	1,760	27%
Unauthorized Immigrant	2,514	22%

CHILD POPULATION (< 18 YEARS OLD)	25,396	
Nativity and Legal Status		
U.S.-born	23,632	93%
Immigrant	1,764	7%
Unauthorized Immigrant	996	4%
Resides with at Least One Immigrant Parent [4]	16,424	65%
of those children, share US-born	14,767	90%
Resides with at Least One Unauthorized Immigrant Parent [4]	9,263	36%
of those children, share US-born	8,206	89%
Child Poverty (Family Income < 150% of Poverty Line) [4]	15,906	63%
Resides with ≥ 1 U.S.-born Parent	5,421	59%
Resides with ≥ 1 Immigrant Parent	10,775	66%
Resides with ≥ 1 Naturalized Parent	1,678	47%
Resides with ≥ 1 Authorized Immigrant Parent	4,440	73%
Resides with ≥ 1 Unauthorized Immigrant Parent	6,458	70%

UNAUTHORIZED IMMIGRANT POPULATION		
Places of origin		
Mexico	10,733	74%
Central America	2,239	15%
Asia	1,286	9%
Rest of the World	190	1%
Female	6,577	46%
Age and Time in Country (Medians)		
Age	33 years	
Age First Arrived in Country	20 years	
Years Residing in the USA	11 years	
Labor Force Participation (Age 18-64 Years Old)	10,553	79%
Male Participation	6,937	96%
of which, share employed	6,227	90%
of employed, share full-time	3,962	64%
Female Participation	3,616	59%
of which, share employed	3,097	86%
of employed, share full-time	1,705	55%
Top 5 Industries	5,823	72%
Retail Trade	2,225	28%
Manufacturing	1,238	15%
Construction	1,114	14%
Business and Repair Services	626	8%
Professional and Related Services	620	8%
Top 5 Occupations	4,467	56%
Food Preparation and Service Occupations	1,136	14%
Machine Operators, Assemblers, and Inspectors	1,117	14%
Helpers in Construction and Freight Handlers	852	11%
Construction Trades	695	9%
Sales Occupations	667	8%

Methodology

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Notes

(-) indicates that the underlying number of observations is too small to make a reliable calculation of the variable in question.

[1] Virtually all U.S.-born respondents in the ACS either report speaking English very well or speak no other language but English at home.

[2] These are computed at the individual level using the ACS variable indicating the ratio of family income to the poverty line by family type.

[3] Employer and low-income insurance coverage do not add up to total coverage which also includes private purchased insurance, veteran coverage, etc.

[4] The denominator is the number of children residing with at least one parent.

2008-2012 Population Profile: Building Healthy Communities South Los Angeles

TOTAL POPULATION	91,793	
Race and Ethnicity		
Non-Hispanic White	1,183	1%
Latino	71,239	78%
Asian or Pacific Islander	571	1%
Black	17,637	19%
Other	1,164	1%
Nativity and Legal Status		
U.S.-born (U.S. Citizen)	50,642	55%
Foreign-born ("Immigrant")	41,151	45%
Naturalized Immigrant (U.S. Citizen)	7,556	8%
Authorized Immigrant (Non-U.S. Citizen)	10,462	11%
Unauthorized Immigrant (Non-U.S. Citizen)	23,133	25%
Speaks English Well (among Those Age ≥ 5 Years Old) [1]	56,645	68%
Immigrant	56,645	37%
Naturalized Immigrant	4,347	58%
Authorized Immigrant	4,099	39%
Unauthorized Immigrant	6,868	30%
Poverty (Family Income < 150% of Poverty Line) [2]	49,447	54%
U.S.-born	27,324	54%
Immigrant	22,123	54%
Naturalized Immigrant	2,625	35%
Authorized Immigrant	4,939	47%
Unauthorized Immigrant	14,559	63%
Homeownership	6,845	29%
U.S.-born	3,275	34%
Immigrant	3,570	25%
Naturalized Immigrant	1,759	48%
Authorized Immigrant	1,065	30%
Unauthorized Immigrant	746	11%

INSURANCE/COVERAGE FOR WORKING AGE POPULATION (25-64)		
Has Medical Insurance Coverage	20,702	45%
U.S.-born	8,817	67%
Immigrant	11,885	37%
Naturalized Immigrant	3,993	61%
Authorized Immigrant	3,445	43%
Unauthorized Immigrant	4,447	25%
Has Employer-Sponsored Medical Insurance Coverage	10,784	24%
U.S.-born	5,064	39%
Immigrant	5,720	18%
Naturalized Immigrant	2,546	39%
Authorized Immigrant	1,536	19%
Unauthorized Immigrant	1,638	9%
Has Low-Income Government Insurance or Assistance (e.g., Medi-Cal) [3]	9,024	20%
U.S.-born	3,270	25%
Immigrant	5,754	18%
Naturalized Immigrant	1,322	20%
Authorized Immigrant	1,671	21%
Unauthorized Immigrant	2,761	15%

CHILD POPULATION (< 18 YEARS OLD)	30,261	
Nativity and Legal Status		
U.S.-born	27,591	91%
Immigrant	2,670	9%
Unauthorized Immigrant	1,661	5%
Resides with at Least One Immigrant Parent [4]	21,171	70%
of those children, share US-born	18,980	90%
Resides with at Least One Unauthorized Immigrant Parent [4]	14,042	46%
of those children, share US-born	12,328	88%
Child Poverty (Family Income < 150% of Poverty Line) [4]	20,284	67%
Resides with ≥ 1 U.S.-born Parent	4,864	63%
Resides with ≥ 1 Immigrant Parent	14,804	70%
Resides with ≥ 1 Naturalized Parent	2,153	54%
Resides with ≥ 1 Authorized Immigrant Parent	3,993	64%
Resides with ≥ 1 Unauthorized Immigrant Parent	10,689	76%

UNAUTHORIZED IMMIGRANT POPULATION		
Places of origin		
Mexico	15,249	66%
Central America	7,559	33%
Asia	33	0%
Rest of the World	292	1%
Female	10,431	45%
Age and Time in Country (Medians)		
Age	32 years	
Age First Arrived in Country	20 years	
Years Residing in the USA	12 years	
Labor Force Participation (Age 18-64 Years Old)	15,875	74%
Male Participation	10,597	89%
of which, share employed	9,443	89%
of employed, share full-time	7,147	76%
Female Participation	5,279	56%
of which, share employed	4,558	86%
of employed, share full-time	2,468	54%
Top 5 Industries	9,600	79%
Manufacturing	3,298	27%
Retail Trade	2,663	22%
Construction	1,447	12%
Business and Repair Services	1,374	11%
Wholesale Trade	818	7%
Top 5 OccupatIons	7,886	65%
Machine Operators, Assemblers, and Inspectors	3,153	26%
Helpers in Construction and Freight Handlers	1,643	13%
Cleaning, Building and Household Service Occupations	1,273	10%
Sales Occupations	1,009	8%
Construction Trades	808	7%

Methodology

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Notes

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[1] Virtually all U.S.-born respondents in the ACS either report speaking English very well or speak no other language but English at home.
[2] These are computed at the individual level using the ACS variable indicating the ratio of family income to the poverty line by family type.
[3] Employer and low-income insurance coverage do not add up to total coverage which also includes private purchased insurance, veteran coverage, etc.
[4] The denominator is the number of children residing with at least one parent.

2008-2012 Population Profile: Building Healthy Communities Boyle Heights

TOTAL POPULATION	92,682	
Race and Ethnicity		
Non-Hispanic White	1,675	2%
Latino	87,262	94%
Asian or Pacific Islander	2,446	3%
Black	811	1%
Other	487	1%
Nativity and Legal Status		
U.S.-born (U.S. Citizen)	47,521	51%
Foreign-born ("Immigrant")	45,161	49%
Naturalized Immigrant (U.S. Citizen)	12,782	14%
Authorized Immigrant (Non-U.S. Citizen)	12,961	14%
Unauthorized Immigrant (Non-U.S. Citizen)	19,418	21%
Speaks English Well (among Those Age ≥ 5 Years Old) [1]	56,298	66%
Immigrant	56,298	39%
Naturalized Immigrant	6,316	50%
Authorized Immigrant	5,108	40%
Unauthorized Immigrant	6,330	33%
Poverty (Family Income < 150% of Poverty Line) [2]	43,738	48%
U.S.-born	21,651	46%
Immigrant	22,087	49%
Naturalized Immigrant	4,622	36%
Authorized Immigrant	6,050	47%
Unauthorized Immigrant	11,415	59%
Homeownership	4,990	19%
U.S.-born	1,626	23%
Immigrant	3,364	18%
Naturalized Immigrant	2,031	29%
Authorized Immigrant	927	16%
Unauthorized Immigrant	406	7%
INSURANCE/COVERAGE FOR WORKING AGE POPULATION (25-64)		
Has Medical Insurance Coverage	23,992	51%
U.S.-born	9,523	71%
Immigrant	14,469	43%
Naturalized Immigrant	5,485	63%
Authorized Immigrant	4,120	43%
Unauthorized Immigrant	4,864	32%
Has Employer-Sponsored Medical Insurance Coverage	12,777	27%
U.S.-born	5,861	44%
Immigrant	6,916	21%
Naturalized Immigrant	3,396	39%
Authorized Immigrant	1,757	18%
Unauthorized Immigrant	1,763	12%
Has Low-Income Government Insurance or Assistance (e.g., Medi-Cal) [3]	9,031	19%
U.S.-born	2,851	21%
Immigrant	6,180	18%
Naturalized Immigrant	1,790	21%
Authorized Immigrant	1,779	19%
Unauthorized Immigrant	2,611	17%

CHILD POPULATION (< 18 YEARS OLD)	26,198	
Nativity and Legal Status		
U.S.-born	24,121	92%
Immigrant	2,077	8%
Unauthorized Immigrant	1,488	6%
Resides with at Least One Immigrant Parent [4]	19,309	74%
of those children, share US-born	17,373	90%
Resides with at Least One Unauthorized Immigrant Parent [4]	11,932	46%
of those children, share US-born	10,422	87%
Child Poverty (Family Income < 150% of Poverty Line) [4]	16,024	61%
Resides with ≥ 1 U.S.-born Parent	3,230	47%
Resides with ≥ 1 Immigrant Parent	12,749	66%
Resides with ≥ 1 Naturalized Parent	2,381	50%
Resides with ≥ 1 Authorized Immigrant Parent	3,796	60%
Resides with ≥ 1 Unauthorized Immigrant Parent	8,441	71%
UNAUTHORIZED IMMIGRANT POPULATION		
Places of origin		
Mexico	17,057	88%
Central America	1,939	10%
Asia	317	2%
Rest of the World	104	1%
Female	9,354	48%
Age and Time in Country (Medians)		
Age	32 years	
Age First Arrived in Country	20 years	
Years Residing in the USA	12 years	
Labor Force Participation (Age 18-64 Years Old)	12,859	72%
Male Participation	8,179	89%
of which, share employed	7,596	93%
of employed, share full-time	5,499	72%
Female Participation	4,680	54%
of which, share employed	4,053	87%
of employed, share full-time	2,474	61%
Top 5 Industries	8,123	78%
Manufacturing	2,509	24%
Retail Trade	2,351	23%
Construction	1,435	14%
Business and Repair Services	973	9%
Wholesale Trade	855	8%
Top 5 Occupations	6,614	64%
Machine Operators, Assemblers, and Inspectors	2,510	24%
Helpers in Construction and Freight Handlers	1,281	12%
Sales Occupations	1,276	12%
Transportation and Material Movers (Except Helpers/Laborers)	786	8%
Food Preparation and Service Occupations	761	7%

Methodology

The results in this fact sheet are based on a three-step method the USC Center for the Study of Immigrant Integration (CSII) uses to estimate the undocumented. Starting with the pooled 2008-2012 American Community Survey (ACS) Public Use Microdata Sample data, the first step involves determining who among the non-citizen population is highly unlikely to be undocumented based on certain characteristics. The second step calculates the probability of being undocumented for the remaining non-citizen population by applying coefficients based on a regression analysis of data from the 2008 Survey of Income and Program Participation. The third step then utilizes these strict cut-offs and probability estimates to fit the ACS microdata to national aggregate estimates for the undocumented by country of origin.

Notes

(-) indicates that the underlying number of observations is too small to make a reliable calculation of the variable in question.

[1] Virtually all U.S.-born respondents in the ACS either report speaking English very well or speak no other language but English at home.

[2] These are computed at the individual level using the ACS variable indicating the ratio of family income to the poverty line by family type.

[3] Employer and low-income insurance coverage do not add up to total coverage which also includes private purchased insurance, veteran coverage, etc.

[4] The denominator is the number of children residing with at least one parent.

2008-2012 Population Profile: Building Healthy Communities Del Norte County

TOTAL POPULATION	28,252	
Race and Ethnicity		
Non-Hispanic White	18,079	64%
Latino	5,144	18%
Asian or Pacific Islander	822	3%
Black	1,125	4%
Other	3,082	11%
Nativity and Legal Status		
U.S.-born (U.S. Citizen)	26,084	92%
Foreign-born ("Immigrant")	2,168	8%
Naturalized Immigrant (U.S. Citizen)	818	3%
Authorized Immigrant (Non-U.S. Citizen)	662	2%
Unauthorized Immigrant (Non-U.S. Citizen)	688	2%
Speaks English Well (among Those Age ≥ 5 Years Old) [1]	26,012	97%
Immigrant	26,012	72%
Naturalized Immigrant	727	89%
Authorized Immigrant	524	80%
Unauthorized Immigrant	307	45%
Poverty (Family Income < 150% of Poverty Line) [2]	6,445	27%
U.S.-born	6,073	23%
Immigrant	372	17%
Naturalized Immigrant	113	14%
Authorized Immigrant	162	24%
Unauthorized Immigrant	97	14%
Homeownership	6,818	63%
U.S.-born	6,521	64%
Immigrant	297	50%
Naturalized Immigrant	197	72%
Authorized Immigrant	63	29%
Unauthorized Immigrant	37	38%
INSURANCE/COVERAGE FOR WORKING AGE POPULATION (25-64)		
Has Medical Insurance Coverage	11,913	73%
U.S.-born	10,921	75%
Immigrant	992	58%
Naturalized Immigrant	471	83%
Authorized Immigrant	264	47%
Unauthorized Immigrant	257	44%
Has Employer-Sponsored Medical Insurance Coverage	7,015	43%
U.S.-born	6,614	45%
Immigrant	401	24%
Naturalized Immigrant	225	40%
Authorized Immigrant	84	15%
Unauthorized Immigrant	92	16%
Has Low-Income Government Insurance or Assistance (e.g., Medi-Cal) [3]	3,984	25%
U.S.-born	3,531	24%
Immigrant	453	27%
Naturalized Immigrant	87	15%
Authorized Immigrant	180	32%
Unauthorized Immigrant	186	32%

CHILD POPULATION (< 18 YEARS OLD)	4,758	
Nativity and Legal Status		
U.S.-born	4,676	98%
Immigrant	82	2%
Unauthorized Immigrant	6	0%
Resides with at Least One Immigrant Parent [4]	770	16%
of those children, share US-born	730	95%
Resides with at Least One Unauthorized Immigrant Parent [4]	286	6%
of those children, share US-born	280	98%
Child Poverty (Family Income < 150% of Poverty Line) [4]	1,800	38%
Resides with ≥ 1 U.S.-born Parent	1,450	37%
Resides with ≥ 1 Immigrant Parent	400	52%
Resides with ≥ 1 Naturalized Parent	26	11%
Resides with ≥ 1 Authorized Immigrant Parent	220	69%
Resides with ≥ 1 Unauthorized Immigrant Parent	166	58%
UNAUTHORIZED IMMIGRANT POPULATION		
Places of origin		
Mexico	604	88%
Central America	-	0%
Asia	84	12%
Rest of the World	-	0%
Female	134	20%
Age and Time in Country (Medians)		
Age	33 years	
Age First Arrived in Country	19 years	
Years Residing in the USA	13 years	
Labor Force Participation (Age 18-64 Years Old)	148	22%
Male Participation	74	13%
of which, share employed	65	88%
of employed, share full-time	38	58%
Female Participation	74	58%
of which, share employed	40	54%
of employed, share full-time	34	84%
Top 5 Industries	101	96%
Manufacturing	41	39%
Retail Trade	24	23%
Agriculture, Foresting, Fishing and Hunting	16	15%
Construction	12	11%
Business and Repair Services	8	8%
Top 5 Occupations	88	83%
Administrative Support Occupations, Including Clerical	34	32%
Sales Occupations	17	16%
Farming, Forestry, and Fishing Occupations	16	15%
Executive, Administrative, and Managerial Occupations	12	11%
Transportation and Material Movers (Except Helpers/Laborers)	9	8%

Methodology

The results in this fact sheet are based on a three-step method the USC Center for the Study of Immigrant Integration (CSII) uses to estimate the undocumented. Starting with the pooled 2008-2012 American Community Survey (ACS) Public Use Microdata Sample data, the first step involves determining who among the non-citizen population is highly unlikely to be undocumented based on certain characteristics. The second step calculates the probability of being undocumented for the remaining non-citizen population by applying coefficients based on a regression analysis of data from the 2008 Survey of Income and Program Participation. The third step then utilizes these strict cut-offs and probability estimates to fit the ACS microdata to national aggregate estimates for the undocumented by country of origin.

Notes

(-) indicates that the underlying number of observations is too small to make a reliable calculation of the variable in question.

[1] Virtually all U.S.-born respondents in the ACS either report speaking English very well or speak no other language but English at home.

[2] These are computed at the individual level using the ACS variable indicating the ratio of family income to the poverty line by family type.

[3] Employer and low-income insurance coverage do not add up to total coverage which also includes private purchased insurance, veteran coverage, etc.

[4] The denominator is the number of children residing with at least one parent.

2008-2012 Population Profile: Building Healthy Communities South Sacramento

TOTAL POPULATION	71,599	
Race and Ethnicity		
Non-Hispanic White	14,989	21%
Latino	29,602	41%
Asian or Pacific Islander	15,312	21%
Black	8,476	12%
Other	3,220	4%
Nativity and Legal Status		
U.S.-born (U.S. Citizen)	50,658	71%
Foreign-born ("Immigrant")	20,941	29%
Naturalized Immigrant (U.S. Citizen)	8,306	12%
Authorized Immigrant (Non-U.S. Citizen)	6,166	9%
Unauthorized Immigrant (Non-U.S. Citizen)	6,469	9%
Speaks English Well (among Those Age ≥ 5 Years Old) [1]	57,559	87%
Immigrant	12,897	62%
Naturalized Immigrant	6,088	73%
Authorized Immigrant	3,649	59%
Unauthorized Immigrant	3,160	49%
Poverty (Family Income < 150% of Poverty Line) [2]	29,290	41%
U.S.-born	19,508	39%
Immigrant	9,782	47%
Naturalized Immigrant	2,512	30%
Authorized Immigrant	3,267	53%
Unauthorized Immigrant	4,003	62%
Homeownership	11,360	48%
U.S.-born	7,915	51%
Immigrant	3,445	42%
Naturalized Immigrant	2,322	57%
Authorized Immigrant	696	33%
Unauthorized Immigrant	427	22%

INSURANCE/COVERAGE FOR WORKING AGE POPULATION (25-64)		
Has Medical Insurance Coverage	25,290	72%
U.S.-born	16,606	82%
Immigrant	8,684	59%
Naturalized Immigrant	4,584	75%
Authorized Immigrant	2,624	62%
Unauthorized Immigrant	1,476	33%
Has Employer-Sponsored Medical Insurance Coverage	17,308	49%
U.S.-born	12,204	60%
Immigrant	5,104	34%
Naturalized Immigrant	3,175	52%
Authorized Immigrant	1,286	31%
Unauthorized Immigrant	643	14%
Has Low-Income Government Insurance or Assistance (e.g., Medi-Cal) [3]	6,278	18%
U.S.-born	3,300	16%
Immigrant	2,978	20%
Naturalized Immigrant	1,135	19%
Authorized Immigrant	1,064	25%
Unauthorized Immigrant	779	17%

CHILD POPULATION (< 18 YEARS OLD)	20,584	
Nativity and Legal Status		
U.S.-born	19,098	93%
Immigrant	1,486	7%
Unauthorized Immigrant	867	4%
Resides with at Least One Immigrant Parent [4]	9,800	48%
of those children, share US-born	8,408	86%
Resides with at Least One Unauthorized Immigrant Parent [4]	4,648	23%
of those children, share US-born	3,765	81%
Child Poverty (Family Income < 150% of Poverty Line) [4]	11,668	57%
Resides with ≥ 1 U.S.-born Parent	5,166	50%
Resides with ≥ 1 Immigrant Parent	6,028	62%
Resides with ≥ 1 Naturalized Parent	1,880	44%
Resides with ≥ 1 Authorized Immigrant Parent	2,253	69%
Resides with ≥ 1 Unauthorized Immigrant Parent	3,291	71%

UNAUTHORIZED IMMIGRANT POPULATION		
Places of origin		
Mexico	4,780	74%
Central America	551	9%
Asia	1,002	15%
Rest of the World	137	2%
Female	3,173	49%
Age and Time in Country (Medians)		
Age	30 years	
Age First Arrived in Country	19 years	
Years Residing in the USA	9 years	
Labor Force Participation (Age 18-64 Years Old)	4,089	73%
Male Participation	2,645	89%
of which, share employed	2,051	78%
of employed, share full-time	1,054	51%
Female Participation	1,444	55%
of which, share employed	1,067	74%
of employed, share full-time	377	35%
Top 5 Industries	2,115	85%
Retail Trade	676	27%
Construction	554	22%
Agriculture, Foresting, Fishing and Hunting	475	19%
Business and Repair Services	261	10%
Personal Services	149	6%
Top 5 OccupatIons	1,859	74%
Farming, Forestry, and Fishing Occupations	547	22%
Food Preparation and Service Occupations	475	19%
Construction Trades	320	13%
Helpers in Construction and Freight Handlers	285	11%
Cleaning, Building and Household Service Occupations	232	9%

Methodology

The results in this fact sheet are based on a three-step method the USC Center for the Study of Immigrant Integration (CSII) uses to estimate the undocumented. Starting with the pooled 2008-2012 American Community Survey (ACS) Public Use Microdata Sample data, the first step involves determining who among the non-citizen population is highly unlikely to be undocumented based on certain characteristics. The second step calculates the probability of being undocumented for the remaining non-citizen population by applying coefficients based on a regression analysis of data from the 2008 Survey of Income and Program Participation. The third step then utilizes these strict cut-offs and probability estimates to fit the ACS microdata to national aggregate estimates for the undocumented by country of origin.

Notes

(-) indicates that the underlying number of observations is too small to make a reliable calculation of the variable in question.

[1] Virtually all U.S.-born respondents in the ACS either report speaking English very well or speak no other language but English at home.

[2] These are computed at the individual level using the ACS variable indicating the ratio of family income to the poverty line by family type.

[3] Employer and low-income insurance coverage do not add up to total coverage which also includes private purchased insurance, veteran coverage, etc.

[4] The denominator is the number of children residing with at least one parent.

2008-2012 Population Profile: Building Healthy Communities Richmond

TOTAL POPULATION	40,870	
Race and Ethnicity		
Non-Hispanic White	1,914	5%
Latino	24,218	59%
Asian or Pacific Islander	2,201	5%
Black	11,442	28%
Other	942	2%
Nativity and Legal Status		
U.S.-born (U.S. Citizen)	25,717	63%
Foreign-born ("Immigrant")	15,153	37%
Naturalized Immigrant (U.S. Citizen)	3,059	7%
Authorized Immigrant (Non-U.S. Citizen)	3,958	10%
Unauthorized Immigrant (Non-U.S. Citizen)	8,136	20%
Speaks English Well (among Those Age ≥ 5 Years Old) [1]	30,169	82%
Immigrant	8,734	58%
Naturalized Immigrant	2,272	74%
Authorized Immigrant	2,408	61%
Unauthorized Immigrant	4,054	50%
Poverty (Family Income < 150% of Poverty Line) [2]	15,640	39%
U.S.-born	9,766	38%
Immigrant	5,874	39%
Naturalized Immigrant	672	22%
Authorized Immigrant	1,506	38%
Unauthorized Immigrant	3,696	45%
Homeownership	4,779	40%
U.S.-born	2,631	40%
Immigrant	2,148	40%
Naturalized Immigrant	934	62%
Authorized Immigrant	597	44%
Unauthorized Immigrant	617	25%
INSURANCE/COVERAGE FOR WORKING AGE POPULATION (25-64)		
Has Medical Insurance Coverage	13,780	69%
U.S.-born	7,049	79%
Immigrant	6,731	61%
Naturalized Immigrant	1,846	77%
Authorized Immigrant	1,770	60%
Unauthorized Immigrant	3,115	54%
Has Employer-Sponsored Medical Insurance Coverage	9,453	47%
U.S.-born	4,529	51%
Immigrant	4,924	44%
Naturalized Immigrant	1,524	63%
Authorized Immigrant	1,314	44%
Unauthorized Immigrant	2,086	36%
Has Low-Income Government Insurance or Assistance (e.g., Medi-Cal) [3]	3,623	18%
U.S.-born	2,020	23%
Immigrant	1,603	14%
Naturalized Immigrant	295	12%
Authorized Immigrant	346	12%
Unauthorized Immigrant	962	17%

CHILD POPULATION (< 18 YEARS OLD)	13,195	
Nativity and Legal Status		
U.S.-born	11,774	89%
Immigrant	1,421	11%
Unauthorized Immigrant	1,100	8%
Resides with at Least One Immigrant Parent [4]	8,420	64%
of those children, share US-born	7,059	84%
Resides with at Least One Unauthorized Immigrant Parent [4]	5,252	40%
of those children, share US-born	4,113	78%
Child Poverty (Family Income < 150% of Poverty Line) [4]	6,150	47%
Resides with ≥ 1 U.S.-born Parent	1,918	41%
Resides with ≥ 1 Immigrant Parent	3,994	47%
Resides with ≥ 1 Naturalized Parent	904	38%
Resides with ≥ 1 Authorized Immigrant Parent	1,515	47%
Resides with ≥ 1 Unauthorized Immigrant Parent	2,761	53%
UNAUTHORIZED IMMIGRANT POPULATION		
Places of origin		
Mexico	5,621	69%
Central America	1,608	20%
Asia	387	5%
Rest of the World	520	6%
Female	4,234	52%
Age and Time in Country (Medians)		
Age	31 years	
Age First Arrived in Country	20 years	
Years Residing in the USA	10 years	
Labor Force Participation (Age 18-64 Years Old)	5,404	78%
Male Participation	3,145	93%
of which, share employed	2,921	93%
of employed, share full-time	1,730	59%
Female Participation	2,259	64%
of which, share employed	1,741	77%
of employed, share full-time	928	53%
Top 5 Industries	3,142	77%
Construction	1,053	26%
Business and Repair Services	700	17%
Retail Trade	587	14%
Manufacturing	500	12%
Professional and Related Services	302	7%
Top 5 Occupations	3,154	77%
Cleaning, Building and Household Service Occupations	916	22%
Helpers in Construction and Freight Handlers	760	19%
Construction Trades	698	17%
Food Preparation and Service Occupations	424	10%
Machine Operators, Assemblers, and Inspectors	356	9%

Methodology

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Notes

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[1] Virtually all U.S.-born respondents in the ACS either report speaking English very well or speak no other language but English at home.

[2] These are computed at the individual level using the ACS variable indicating the ratio of family income to the poverty line by family type.

[3] Employer and low-income insurance coverage do not add up to total coverage which also includes private purchased insurance, veteran coverage, etc.

[4] The denominator is the number of children residing with at least one parent.

2008-2012 Population Profile: Building Healthy Communities East Oakland

TOTAL POPULATION	89,737	
Race and Ethnicity		
Non-Hispanic White	3,274	4%
Latino	45,579	51%
Asian or Pacific Islander	5,544	6%
Black	32,982	37%
Other	2,358	3%
Nativity and Legal Status		
U.S.-born (U.S. Citizen)	59,914	67%
Foreign-born ("Immigrant")	29,823	33%
Naturalized Immigrant (U.S. Citizen)	7,062	8%
Authorized Immigrant (Non-U.S. Citizen)	6,352	7%
Unauthorized Immigrant (Non-U.S. Citizen)	16,409	18%
Speaks English Well (among Those Age ≥ 5 Years Old) [1]	64,415	79%
Immigrant	13,568	46%
Naturalized Immigrant	4,934	70%
Authorized Immigrant	3,220	51%
Unauthorized Immigrant	5,414	33%
Poverty (Family Income < 150% of Poverty Line) [2]	37,285	42%
U.S.-born	26,058	43%
Immigrant	11,227	38%
Naturalized Immigrant	1,731	25%
Authorized Immigrant	2,154	34%
Unauthorized Immigrant	7,342	45%
Homeownership	10,447	38%
U.S.-born	6,624	38%
Immigrant	3,823	38%
Naturalized Immigrant	2,098	64%
Authorized Immigrant	830	38%
Unauthorized Immigrant	895	20%

INSURANCE/COVERAGE FOR WORKING AGE POPULATION (25-64)		
Has Medical Insurance Coverage	30,852	69%
U.S.-born	18,072	79%
Immigrant	12,780	58%
Naturalized Immigrant	4,527	81%
Authorized Immigrant	3,042	63%
Unauthorized Immigrant	5,211	44%
Has Employer-Sponsored Medical Insurance Coverage	19,131	43%
U.S.-born	11,220	49%
Immigrant	7,911	36%
Naturalized Immigrant	3,443	62%
Authorized Immigrant	1,743	36%
Unauthorized Immigrant	2,725	23%
Has Low-Income Government Insurance or Assistance (e.g., Medi-Cal) [3]	10,217	23%
U.S.-born	5,974	26%
Immigrant	4,243	19%
Naturalized Immigrant	866	16%
Authorized Immigrant	1,005	21%
Unauthorized Immigrant	2,372	20%

CHILD POPULATION (< 18 YEARS OLD)	26,704	
Nativity and Legal Status		
U.S.-born	24,289	91%
Immigrant	2,415	9%
Unauthorized Immigrant	1,743	7%
Resides with at Least One Immigrant Parent [4]	13,929	52%
of those children, share US-born	11,818	85%
Resides with at Least One Unauthorized Immigrant Parent [4]	9,038	34%
of those children, share US-born	7,130	79%
Child Poverty (Family Income < 150% of Poverty Line) [4]	14,538	54%
Resides with ≥ 1 U.S.-born Parent	6,749	57%
Resides with ≥ 1 Immigrant Parent	7,179	52%
Resides with ≥ 1 Naturalized Parent	1,045	27%
Resides with ≥ 1 Authorized Immigrant Parent	2,439	56%
Resides with ≥ 1 Unauthorized Immigrant Parent	5,390	60%

UNAUTHORIZED IMMIGRANT POPULATION		
Places of origin		
Mexico	12,310	75%
Central America	3,936	24%
Asia	153	1%
Rest of the World	10	0%
Female	7,330	45%
Age and Time in Country (Medians)		
Age	31 years	
Age First Arrived in Country	20 years	
Years Residing in the USA	10 years	
Labor Force Participation (Age 18-64 Years Old)	11,046	76%
Male Participation	8,015	97%
of which, share employed	7,228	90%
of employed, share full-time	4,253	59%
Female Participation	3,031	48%
of which, share employed	2,587	85%
of employed, share full-time	1,455	56%
Top 5 Industries	6,738	83%
Construction	2,257	28%
Retail Trade	2,059	25%
Manufacturing	928	11%
Business and Repair Services	874	11%
Personal Services	620	8%
Top 5 Occupatlons	5,682	70%
Helpers in Construction and Freight Handlers	1,792	22%
Cleaning, Building and Household Service Occupations	1,284	16%
Construction Trades	1,136	14%
Food Preparation and Service Occupations	964	12%
Machine Operators, Assemblers, and Inspectors	506	6%

Methodology

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[1] Virtually all U.S.-born respondents in the ACS either report speaking English very well or speak no other language but English at home.

[2] These are computed at the individual level using the ACS variable indicating the ratio of family income to the poverty line by family type.

[3] Employer and low-income insurance coverage do not add up to total coverage which also includes private purchased insurance, veteran coverage, etc.

[4] The denominator is the number of children residing with at least one parent.

2008-2012 Population Profile: Building Healthy Communities Southwest and East Merced

TOTAL POPULATION	62,660	
Race and Ethnicity		
Non-Hispanic White	14,063	22%
Latino	38,753	62%
Asian or Pacific Islander	5,823	9%
Black	2,550	4%
Other	1,471	2%
Nativity and Legal Status		
U.S.-born (U.S. Citizen)	44,904	72%
Foreign-born ("Immigrant")	17,756	28%
Naturalized Immigrant (U.S. Citizen)	5,718	9%
Authorized Immigrant (Non-U.S. Citizen)	5,012	8%
Unauthorized Immigrant (Non-U.S. Citizen)	7,026	11%
Speaks English Well (among Those Age ≥ 5 Years Old) [1]	47,761	84%
Immigrant	9,184	52%
Naturalized Immigrant	4,229	74%
Authorized Immigrant	2,372	47%
Unauthorized Immigrant	2,583	37%
Poverty (Family Income < 150% of Poverty Line) [2]	25,453	41%
U.S.-born	17,130	38%
Immigrant	8,323	47%
Naturalized Immigrant	1,606	28%
Authorized Immigrant	2,344	47%
Unauthorized Immigrant	4,373	62%
Homeownership	8,555	49%
U.S.-born	5,555	53%
Immigrant	3,000	43%
Naturalized Immigrant	1,745	64%
Authorized Immigrant	719	44%
Unauthorized Immigrant	536	20%

INSURANCE/COVERAGE FOR WORKING AGE POPULATION (25-64)		
Has Medical Insurance Coverage	20,725	71%
U.S.-born	12,570	80%
Immigrant	8,155	61%
Naturalized Immigrant	3,199	74%
Authorized Immigrant	2,470	63%
Unauthorized Immigrant	2,486	48%
Has Employer-Sponsored Medical Insurance Coverage	12,534	43%
U.S.-born	7,961	50%
Immigrant	4,573	34%
Naturalized Immigrant	2,080	48%
Authorized Immigrant	1,327	34%
Unauthorized Immigrant	1,166	23%
Has Low-Income Government Insurance or Assistance (e.g., Medi-Cal) [3]	6,938	24%
U.S.-born	3,826	24%
Immigrant	3,112	23%
Naturalized Immigrant	899	21%
Authorized Immigrant	972	25%
Unauthorized Immigrant	1,241	24%

CHILD POPULATION (< 18 YEARS OLD)	21,043	
Nativity and Legal Status		
U.S.-born	19,800	94%
Immigrant	1,243	6%
Unauthorized Immigrant	933	4%
Resides with at Least One Immigrant Parent [4]	10,937	52%
of those children, share US-born	9,789	90%
Resides with at Least One Unauthorized Immigrant Parent [4]	5,476	26%
of those children, share US-born	4,498	82%
Child Poverty (Family Income < 150% of Poverty Line) [4]	10,783	51%
Resides with ≥ 1 U.S.-born Parent	4,287	40%
Resides with ≥ 1 Immigrant Parent	6,734	62%
Resides with ≥ 1 Naturalized Parent	1,240	35%
Resides with ≥ 1 Authorized Immigrant Parent	2,486	59%
Resides with ≥ 1 Unauthorized Immigrant Parent	4,213	77%
UNAUTHORIZED IMMIGRANT POPULATION		
Places of origin		
Mexico	6,420	91%
Central America	186	3%
Asia	387	6%
Rest of the World	33	0%
Female	3,488	50%
Age and Time in Country (Medians)		
Age	32 years	
Age First Arrived in Country	19 years	
Years Residing in the USA	11 years	
Labor Force Participation (Age 18-64 Years Old)	4,407	72%
Male Participation	2,628	86%
of which, share employed	2,348	89%
of employed, share full-time	1,427	61%
Female Participation	1,778	59%
of which, share employed	1,300	73%
of employed, share full-time	413	32%
Top 5 Industries	3,060	92%
Agriculture, Foresting, Fishing and Hunting	1,450	44%
Retail Trade	575	17%
Construction	493	15%
Manufacturing	355	11%
Wholesale Trade	187	6%
Top 5 OccupatIons	2,730	82%
Farming, Forestry, and Fishing Occupations	1,483	45%
Food Preparation and Service Occupations	406	12%
Construction Trades	328	10%
Helpers in Construction and Freight Handlers	309	9%
Machine Operators, Assemblers, and Inspectors	204	6%

Methodology

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Notes

(-) indicates that the underlying number of observations is too small to make a reliable calculation of the variable in question.

[1] Virtually all U.S.-born respondents in the ACS either report speaking English very well or speak no other language but English at home.

[2] These are computed at the individual level using the ACS variable indicating the ratio of family income to the poverty line by family type.

[3] Employer and low-income insurance coverage do not add up to total coverage which also includes private purchased insurance, veteran coverage, etc.

[4] The denominator is the number of children residing with at least one parent.

2008-2012 Population Profile: Building Healthy Communities Central, Southeast, and Southwest Fresno

TOTAL POPULATION	101,900	
Race and Ethnicity		
Non-Hispanic White	7,591	7%
Latino	72,511	71%
Asian or Pacific Islander	10,754	11%
Black	9,275	9%
Other	1,769	2%
Nativity and Legal Status		
U.S.-born (U.S. Citizen)	72,157	71%
Foreign-born ("Immigrant")	29,743	29%
Naturalized Immigrant (U.S. Citizen)	6,685	7%
Authorized Immigrant (Non-U.S. Citizen)	9,054	9%
Unauthorized Immigrant (Non-U.S. Citizen)	14,004	14%
Speaks English Well (among Those Age ≥ 5 Years Old) [1]	72,693	80%
Immigrant	13,170	45%
Naturalized Immigrant	4,453	67%
Authorized Immigrant	4,057	45%
Unauthorized Immigrant	4,660	34%
Poverty (Family Income < 150% of Poverty Line) [2]	59,483	59%
U.S.-born	40,406	56%
Immigrant	19,077	64%
Naturalized Immigrant	3,171	47%
Authorized Immigrant	5,986	66%
Unauthorized Immigrant	9,920	71%
Homeownership	9,389	35%
U.S.-born	5,853	34%
Immigrant	3,536	36%
Naturalized Immigrant	1,619	53%
Authorized Immigrant	986	34%
Unauthorized Immigrant	931	24%

INSURANCE/COVERAGE FOR WORKING AGE POPULATION (25-64)		
Has Medical Insurance Coverage	28,102	62%
U.S.-born	17,798	71%
Immigrant	10,304	50%
Naturalized Immigrant	3,570	79%
Authorized Immigrant	3,420	52%
Unauthorized Immigrant	3,314	35%
Has Employer-Sponsored Medical Insurance Coverage	13,427	30%
U.S.-born	9,093	37%
Immigrant	4,334	21%
Naturalized Immigrant	1,843	41%
Authorized Immigrant	1,406	21%
Unauthorized Immigrant	1,085	11%
Has Low-Income Government Insurance or Assistance (e.g., Medi-Cal) [3]	13,260	29%
U.S.-born	7,716	31%
Immigrant	5,544	27%
Naturalized Immigrant	1,543	34%
Authorized Immigrant	1,802	28%
Unauthorized Immigrant	2,199	23%

CHILD POPULATION (< 18 YEARS OLD)	36,904	
Nativity and Legal Status		
U.S.-born	33,711	91%
Immigrant	3,193	9%
Unauthorized Immigrant	1,556	4%
Resides with at Least One Immigrant Parent [4]	17,306	47%
of those children, share US-born	14,366	83%
Resides with at Least One Unauthorized Immigrant Parent [4]	8,999	24%
of those children, share US-born	7,224	80%
Child Poverty (Family Income < 150% of Poverty Line) [4]	25,697	70%
Resides with ≥ 1 U.S.-born Parent	12,854	65%
Resides with ≥ 1 Immigrant Parent	12,992	75%
Resides with ≥ 1 Naturalized Parent	2,940	60%
Resides with ≥ 1 Authorized Immigrant Parent	5,908	81%
Resides with ≥ 1 Unauthorized Immigrant Parent	7,189	80%

UNAUTHORIZED IMMIGRANT POPULATION		
Places of origin		
Mexico	12,829	92%
Central America	437	3%
Asia	646	5%
Rest of the World	91	1%
Female	5,885	42%
Age and Time in Country (Medians)		
Age	30 years	
Age First Arrived in Country	18 years	
Years Residing in the USA	10 years	
Labor Force Participation (Age 18-64 Years Old)	9,292	75%
Male Participation	6,464	88%
of which, share employed	5,292	82%
of employed, share full-time	2,410	46%
Female Participation	2,828	55%
of which, share employed	2,261	80%
of employed, share full-time	956	42%
Top 5 Industries	4,682	78%
Agriculture, Foresting, Fishing and Hunting	2,224	37%
Retail Trade	747	12%
Construction	708	12%
Business and Repair Services	556	9%
Manufacturing	447	7%
Top 5 Occupations	4,432	73%
Farming, Forestry, and Fishing Occupations	2,328	39%
Helpers in Construction and Freight Handlers	618	10%
Cleaning, Building and Household Service Occupations	570	9%
Construction Trades	467	8%
Food Preparation and Service Occupations	449	7%

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Notes

(-) indicates that the underlying number of observations is too small to make a reliable calculation of the variable in question.

[1] Virtually all U.S.-born respondents in the ACS either report speaking English very well or speak no other language but English at home.

[2] These are computed at the individual level using the ACS variable indicating the ratio of family income to the poverty line by family type.

[3] Employer and low-income insurance coverage do not add up to total coverage which also includes private purchased insurance, veteran coverage, etc.

[4] The denominator is the number of children residing with at least one parent.

2008-2012 Population Profile: Building Healthy Communities East Salinas

TOTAL POPULATION	55,018	
Race and Ethnicity		
Non-Hispanic White	2,142	4%
Latino	50,869	92%
Asian or Pacific Islander	1,366	2%
Black	230	0%
Other	411	1%
Nativity and Legal Status		
U.S.-born (U.S. Citizen)	32,134	58%
Foreign-born ("Immigrant")	22,884	42%
Naturalized Immigrant (U.S. Citizen)	4,317	8%
Authorized Immigrant (Non-U.S. Citizen)	6,069	11%
Unauthorized Immigrant (Non-U.S. Citizen)	12,498	23%
Speaks English Well (among Those Age ≥ 5 Years Old) [1]	32,546	66%
Immigrant	7,578	33%
Naturalized Immigrant	2,558	59%
Authorized Immigrant	2,349	39%
Unauthorized Immigrant	2,671	21%
Poverty (Family Income < 150% of Poverty Line) [2]	24,776	45%
U.S.-born	14,045	44%
Immigrant	10,731	47%
Naturalized Immigrant	1,376	32%
Authorized Immigrant	2,091	34%
Unauthorized Immigrant	7,264	58%
Homeownership	4,961	37%
U.S.-born	2,010	39%
Immigrant	2,951	35%
Naturalized Immigrant	1,343	59%
Authorized Immigrant	915	37%
Unauthorized Immigrant	693	19%

INSURANCE/COVERAGE FOR WORKING AGE POPULATION (25-64)		
Has Medical Insurance Coverage	15,750	60%
U.S.-born	6,592	77%
Immigrant	9,158	52%
Naturalized Immigrant	2,405	74%
Authorized Immigrant	3,153	64%
Unauthorized Immigrant	3,600	38%
Has Employer-Sponsored Medical Insurance Coverage	12,373	47%
U.S.-born	5,106	60%
Immigrant	7,267	41%
Naturalized Immigrant	2,030	63%
Authorized Immigrant	2,365	48%
Unauthorized Immigrant	2,872	30%
Has Low-Income Government Insurance or Assistance (e.g., Medi-Cal) [3]	2,830	11%
U.S.-born	1,117	13%
Immigrant	1,713	10%
Naturalized Immigrant	311	10%
Authorized Immigrant	684	14%
Unauthorized Immigrant	718	8%

CHILD POPULATION (< 18 YEARS OLD)	19,601	
Nativity and Legal Status		
U.S.-born	18,235	93%
Immigrant	1,366	7%
Unauthorized Immigrant	852	4%
Resides with at Least One Immigrant Parent [4]	13,457	69%
of those children, share US-born	12,322	92%
Resides with at Least One Unauthorized Immigrant Parent [4]	8,528	44%
of those children, share US-born	7,676	90%
Child Poverty (Family Income < 150% of Poverty Line) [4]	11,104	57%
Resides with ≥ 1 U.S.-born Parent	3,444	46%
Resides with ≥ 1 Immigrant Parent	7,755	58%
Resides with ≥ 1 Naturalized Parent	802	28%
Resides with ≥ 1 Authorized Immigrant Parent	2,314	49%
Resides with ≥ 1 Unauthorized Immigrant Parent	6,267	73%

UNAUTHORIZED IMMIGRANT POPULATION		
Places of origin		
Mexico	11,906	95%
Central America	551	4%
Asia	25	0%
Rest of the World	15	0%
Female	5,638	45%
Age and Time in Country (Medians)		
Age	32 years	
Age First Arrived in Country	19 years	
Years Residing in the USA	11 years	
Labor Force Participation (Age 18-64 Years Old)	9,268	80%
Male Participation	5,989	92%
of which, share employed	5,416	90%
of employed, share full-time	2,200	41%
Female Participation	3,279	65%
of which, share employed	2,557	78%
of employed, share full-time	957	37%
Top 5 Industries	5,711	87%
Agriculture, Foresting, Fishing and Hunting	3,714	57%
Construction	626	10%
Retail Trade	625	10%
Business and Repair Services	506	8%
Personal Services	240	4%
Top 5 Occupations	5,264	80%
Farming, Forestry, and Fishing Occupations	3,105	47%
Helpers in Construction and Freight Handlers	734	11%
Construction Trades	624	10%
Transportation and Material Movers (Except Helpers/Laborei	468	7%
Machine Operators, Assemblers, and Inspectors	333	5%

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Notes

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[1] Virtually all U.S.-born respondents in the ACS either report speaking English very well or speak no other language but English at home.
[2] These are computed at the individual level using the ACS variable indicating the ratio of family income to the poverty line by family type.
[3] Employer and low-income insurance coverage do not add up to total coverage which also includes private purchased insurance, veteran coverage, etc.
[4] The denominator is the number of children residing with at least one parent.

2008-2012 Population Profile: Building Healthy Communities South Kern

TOTAL POPULATION	75,943	
Race and Ethnicity		
Non-Hispanic White	8,804	12%
Latino	62,326	82%
Asian or Pacific Islander	1,255	2%
Black	2,277	3%
Other	1,281	2%
Nativity and Legal Status		
U.S.-born (U.S. Citizen)	51,400	68%
Foreign-born ("Immigrant")	24,543	32%
Naturalized Immigrant (U.S. Citizen)	6,312	8%
Authorized Immigrant (Non-U.S. Citizen)	7,320	10%
Unauthorized Immigrant (Non-U.S. Citizen)	10,911	14%
Speaks English Well (among Those Age ≥ 5 Years Old) [1]	54,480	80%
Immigrant	11,504	47%
Naturalized Immigrant	4,406	70%
Authorized Immigrant	3,259	45%
Unauthorized Immigrant	3,839	35%
Poverty (Family Income < 150% of Poverty Line) [2]	33,124	44%
U.S.-born	21,561	42%
Immigrant	11,563	47%
Naturalized Immigrant	1,762	28%
Authorized Immigrant	3,101	42%
Unauthorized Immigrant	6,700	61%
Homeownership	10,650	53%
U.S.-born	5,604	54%
Immigrant	5,046	52%
Naturalized Immigrant	2,413	74%
Authorized Immigrant	1,466	46%
Unauthorized Immigrant	1,167	37%

INSURANCE/COVERAGE FOR WORKING AGE POPULATION (25-64)		
Has Medical Insurance Coverage	23,769	66%
U.S.-born	13,465	79%
Immigrant	10,304	55%
Naturalized Immigrant	3,411	70%
Authorized Immigrant	3,203	57%
Unauthorized Immigrant	3,690	44%
Has Employer-Sponsored Medical Insurance Coverage	14,656	41%
U.S.-born	8,194	48%
Immigrant	6,462	34%
Naturalized Immigrant	2,584	53%
Authorized Immigrant	1,910	34%
Unauthorized Immigrant	1,968	24%
Has Low-Income Government Insurance or Assistance (e.g., Medi-Cal) [3]	7,575	21%
U.S.-born	3,887	23%
Immigrant	3,688	20%
Naturalized Immigrant	763	16%
Authorized Immigrant	1,249	22%
Unauthorized Immigrant	1,676	20%

CHILD POPULATION (< 18 YEARS OLD)	26,897	
Nativity and Legal Status		
U.S.-born	25,399	94%
Immigrant	1,498	6%
Unauthorized Immigrant	945	4%
Resides with at Least One Immigrant Parent [4]	15,357	57%
of those children, share US-born	14,123	92%
Resides with at Least One Unauthorized Immigrant Parent [4]	7,825	29%
of those children, share US-born	6,865	88%
Child Poverty (Family Income < 150% of Poverty Line) [4]	13,908	52%
Resides with ≥ 1 U.S.-born Parent	5,704	44%
Resides with ≥ 1 Immigrant Parent	8,266	54%
Resides with ≥ 1 Naturalized Parent	1,686	33%
Resides with ≥ 1 Authorized Immigrant Parent	2,958	51%
Resides with ≥ 1 Unauthorized Immigrant Parent	5,234	67%

UNAUTHORIZED IMMIGRANT POPULATION		
Places of origin		
Mexico	9,803	90%
Central America	888	8%
Asia	71	1%
Rest of the World	149	1%
Female	5,206	48%
Age and Time in Country (Medians)		
Age	33 years	
Age First Arrived in Country	19 years	
Years Residing in the USA	13 years	
Labor Force Participation (Age 18-64 Years Old)	7,731	78%
Male Participation	5,019	92%
of which, share employed	4,475	89%
of employed, share full-time	2,880	64%
Female Participation	2,712	61%
of which, share employed	1,975	73%
of employed, share full-time	942	48%
Top 5 Industries	4,438	82%
Agriculture, Foresting, Fishing and Hunting	2,364	43%
Retail Trade	803	15%
Business and Repair Services	600	11%
Construction	350	6%
Manufacturing	321	6%
Top 5 OccupatIons	3,880	71%
Farming, Forestry, and Fishing Occupations	2,270	42%
Food Preparation and Service Occupations	546	10%
Cleaning, Building and Household Service Occupations	430	8%
Machine Operators, Assemblers, and Inspectors	338	6%
Construction Trades	296	5%

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[3] Employer and low-income insurance coverage do not add up to total coverage which also includes private purchased insurance, veteran coverage, etc.

[4] The denominator is the number of children residing with at least one parent.

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