



**LESSONS LEARNED FROM A PROGRAM  
TO SUSTAIN HEALTH COVERAGE AFTER SEPTEMBER 11  
IN NEW YORK CITY'S CHINATOWN**

Shao-Chee Sim and Carol Peng  
Asian American Federation of New York

July 2004

**ABSTRACT:** This study examines participation in a temporary health care program for workers in New York City's Chinatown neighborhood who were affected by the terrorist attacks of September 11, 2001. Based on 12 focus groups with enrollees and non-enrollees, the authors identified the following key factors in residents' decisions to participate: source of information (many relied on trusted friends, family, or coworkers for information); prior experience with health insurance (enrollees were more than twice as likely to have had past insurance coverage than non-enrollees); and immediate health needs. When implementing similar programs in the future, the authors recommend that officials: 1) complete a community needs assessment to ensure health insurance access for underserved groups; 2) conduct comprehensive community health education campaigns; 3) provide automatic enrollment; 4) provide continuing coverage for enrollees with no alternatives when the program ends; and 5) streamline the enrollment process into public and other health insurance programs.

Support for this research was provided by The Commonwealth Fund. The views presented here are those of the authors and should not be attributed to The Commonwealth Fund or its directors, officers, or staff.

Additional copies of this (#739) and other Commonwealth Fund publications are available online at [www.cmf.org](http://www.cmf.org). To learn about new Fund publications when they appear, visit the Fund's website and [register to receive e-mail alerts](#).



## CONTENTS

About the Authors.....	iv
Research Advisory Board.....	v
Research Team.....	vi
Executive Summary.....	vii
I. Introduction.....	1
II. Community and Participant Profiles.....	4
III. Major Findings.....	13
IV. Lessons for Serving an Immigrant Community.....	28
V. Recommendations for Program Design and Policy.....	31
Appendix A. Demographics.....	35
Appendix B. Methodology.....	40
Appendix C. Service Providers.....	45
Appendix D. References.....	48

## LIST OF FIGURES AND TABLES

Figure 1	Chinatown Study Area with Chinese Population Concentrations.....	2
Figure 2	Enrollees Health Needs and Health Service Use Before and After September 11.....	12
Figure 3	Non-Enrollees Health Needs and Health Service Use Before and After September 11.....	13
Table 1	Focus Group Demographic Profile.....	5
Table 2	Selected Demographics of the Cantonese and the Mandarin/Fuzhounese Speaking Populations.....	6
Table 3	Past Health Coverage of Participants.....	7
Table 4	Sources of Information for Participants.....	14

## ABOUT THE AUTHORS

**Shao-Chee Sim, Ph.D.**, is currently evaluation officer at the Wallace Foundation. He assists in the efforts of the Evaluation Department to guide the Foundation's learning opportunities in the field with regard to out-of-school time activities for children and youth. Dr. Sim was most recently Director of Research at the Asian American Federation of New York, where he led such studies as an economic impact assessment of the September 11 attacks on Chinatown, a mental health needs assessment of victim families of Asian descent and vulnerable groups in Chinatown, and a study of immigrants' health care access experience. Prior to joining the Federation, he held research positions at Columbia University and the University of Texas at Austin. Over the years, he has also involved with a number of Chinatown immigrant rights, voter education, and social service organizations. Sim holds a Ph.D. in public policy from the Lyndon Baines Johnson School of Public Affairs at the University of Texas at Austin and a master's degree in Public Administration from the John F. Kennedy School of Government at Harvard University. Since 2001, he has served as an adjunct professor at the Robert Milano Graduate School of Urban Policy and Management of the New School University.

**Carol Peng, M.S.W.**, serves as the assistant director of research at the Asian American Federation of New York. At the Federation, she has been involved in an economic impact study of the September 11 terrorist attacks on Chinatown, a mental health needs assessment of Asian American victims' families and vulnerable residents of Chinatown, and a study evaluating health care choices and service use of Chinatown workers after the attacks. Prior to joining the Federation, she worked at several research centers in California in the fields of community mental health and ethnic minority psychology, including the Department of Psychiatry at the University of California, San Francisco, and the Departments of Psychology and Social Work at the University of California, Berkeley. She also served for several years as a counselor in the largest mental health residential treatment program for Asian Americans on the West Coast. Ms. Peng holds a master's degree in social work from Columbia University and completed her undergraduate studies in psychology and social welfare at the University of California, Berkeley.

## RESEARCH ADVISORY BOARD\*

May Chen  
Vice President  
UNITE, Local 23-25

Arthur Cusack, M.P.A.  
Administrator  
Charles B. Wang Community Health Center

Jennifer Edwards, Dr.P.H.  
Director, Health Care in New York City  
Program, and Deputy Director, Task Force on  
the Future of Health Insurance  
The Commonwealth Fund

Kathryn Haslanger, J.D., M.S.  
Vice President and Director of Policy Analysis  
United Hospital Fund of New York

Deniz Hom  
Eligibility Specialist  
Charles B. Wang Community Health Center

Audrey Lum, R.N., M.P.A.  
Chief of Clinical Services  
Union Health Center

Len McNally  
Program Director  
New York Community Trust

Henry Mui  
Project Coordinator  
Chinatown Health Partnership at  
Lutheran Family Health Center, Sunset Park

Karen Nelson, M.D., M.P.H.  
Chief Executive Officer and Medical Director  
Union Health Center

Tanaz Pardiwala  
Director of Community Organizing  
Safe Horizon

Steven Rosenberg, M.D., M.P.H.  
Emeritus Clinical Professor of Public Health  
Mailman School of Public Health  
Columbia University

Virginia Tong  
Director of Network Development  
Chinatown Health Partnership at  
Lutheran Family Health Center, Sunset Park

Eugene Tuff  
Marketing Field Trainer  
Affinity Health Plan

Angie Wang  
Program Director  
The September 11th Fund

\* The views expressed in this report are those of the Asian American Federation of New York and do not necessarily reflect the views or positions of the research advisory board.

## RESEARCH TEAM

### *Principal Investigator*

Shao-Chee Sim, Ph.D.\*  
Former Director of Research  
Asian American Federation of New York

### *Project Manager*

Carol Peng, M.S.W.  
Assistant Director of Research  
Asian American Federation of New York

### *Research Team Members*

Anna Lee  
Research Assistant  
Asian American Federation of New York

JoAnn Lee  
Research Intern  
Asian American Federation of New York

Edna Chung, M.P.H.  
Former Research Associate  
Asian American Federation of New York

Katy Ho  
Consultant  
Asian American Federation of New York

\* Dr. Sim is currently employed by The Wallace Foundation as an evaluation officer.

## EXECUTIVE SUMMARY

This is the first study conducted to assess the health needs of the worker population in Manhattan's Chinatown and its utilization of health care services. The study relates specifically to two groups of Chinatown adults: one that chose to enroll in a temporary health care program for workers affected by the terrorist attacks of September 11, 2001, and a second group that did not enroll in the program.

Performed by the Asian American Federation of New York (AAFNY), this study had two goals. The first was to identify and understand the factors that facilitated or hindered people's decisions to participate in this health care program. The research team also wanted to provide insights that public and private service providers could apply in designing and implementing other programs that serve immigrant populations.

Many of the findings in this report can be more broadly applied to a range of health service programs that are designed to serve immigrant populations. The study illustrated several key lessons. For this immigrant population, the source of information, a person's prior experience with health insurance and their immediate health needs were factors that influenced how people made decisions about accessing health care services.

Researchers learned, for example, that to gain the confidence of the community and stimulate participation, the source of information about this health care program had to be a trusted individual. Only a "trusted" person was able to effectively conduct outreach and respond to the needs of eligible participants.

Researchers also noted that potential program participants often did not enroll because of their lack of understanding about health insurance in general, and their fears related to their undocumented immigrant status.

### **The September 11th Fund Health Care Program**

This study focused on the Health Care Program (HCP) that is part of the Ongoing Recovery Program (ORP) of the September 11th Fund. Implemented in August 2002, the HCP had an enrollment deadline of January 31, 2004. It provides up to 12 months of free health care coverage to workers ineligible for public health insurance programs and cannot afford to pay private health insurance premiums. Enrollment requires a two-step application process. Individuals must first enroll with Safe Horizon, a New York City victim's assistance program that manages enrollment and outreach for the ORP HCP, and then enroll with one of the four participating health service sites.

Eligibility for the HCP program is based on several criteria. Individuals must have worked between September 11, 2001, and January 11, 2002, south of Canal Street; or within the boundaries of Broadway, Canal, Delancey, and Essex streets; or at Ronald Reagan National Airport. They must have lost a job, missed four weeks of paid work, or experienced at least a 30 percent loss in overall income prior to January 11, 2002. Individuals also must be currently unemployed, or be underemployed, with at least a 30 percent income loss since September 11, 2001. Finally, they must be ineligible for public health insurance programs but unable to afford private health insurance premiums.

The September 11th Fund reported that as of November 2003, some 14,000 individuals had accessed the health care program in the more than 15 months since its inception. More than 60 percent of enrollees spoke Chinese.

### **Study Methodology**

The research team conducted 12 focus group sessions with a total of 94 participants. All were of Asian descent and employed in Chinatown before September 11, 2001. This study consisted of two populations: six “enrollee” groups that were comprised of individuals enrolled in the HCP, and six “non-enrollee” groups that were comprised of individuals who had completed either none or only one-half of the two-step enrollment process. Middle-aged females from the garment industry—one of the groups most impacted by the September 11 attacks—comprised the majority of focus group participants.

### **Factors That Influence Health Insurance Decisions**

#### *Source of Information*

The study illustrated that participants relied heavily on trusted friends, family or co-workers for information. Fifty percent of enrollees and 64 percent of non-enrollees reported learning about the program through word-of-mouth.

Trust was particularly an issue for undocumented individuals who were fearful because of their immigration status. Some people rejected the program unless they heard about it from a reliable source. The issue of trust also played a role in the fear clients had in sharing personal information. Many were hesitant to provide their phone numbers and other contact information to service providers because of their fears about their immigrant status.



Many people were prompted to enroll after they were able to meet service providers. All four service providers reported that their presence at Safe Horizon information sessions increased their enrollment numbers.

The September 11th Fund's collaboration with Community Based Organizations (CBOs) was key to overcoming the wariness of participants. CBOs were able to reach underserved populations such as the Fujianese, a major Chinatown subgroup, because of their knowledge of and relationship with the community.

### ***Prior Experience with Health Insurance***

A person's prior experience with health insurance also influenced their decision to sign up for the insurance program. Enrollees were more than twice as likely to have had past insurance coverage than non-enrollees, many of whom had no previous health insurance coverage. Specifically, 74 percent of non-enrollees never had health coverage, while the same was true for less than one-third of enrollees (29%).

Non-participants had strong misconceptions about insurance. *"Even if I had September 11 insurance, I don't think it would be good,"* expressed one non-enrollee. *"The appointment times would be too long. If one gets sick, he will not get immediate care through his September 11 insurance. It is useless. I would rather pay for a private doctor out of my own pocket."*

Non-enrollees had heard about various health care programs, but many automatically assumed that they would be ineligible. This trend was quite common among undocumented immigrants, who are ineligible for most government programs. Fear about immigration status influenced many people's decision not to enroll in the program: *"We're afraid that we might be arrested because we are undocumented,"* said one focus group participant. Many Fujianese were not disinterested in the program, but did not enroll because they were unaware of the program or had incomplete information about it.

Participants reported varying degrees of familiarity with insurance and health care services. Those people familiar with the health care system tended to demonstrate a more informed approach to using their health insurance, for example, by using more preventive-care services.

People who lacked health insurance often delayed receiving medical services, and these participants instead endured pain or illnesses as long as possible. Non-enrollee groups were less educated, knew minimal English and were more recent immigrants. Often, they also lacked health insurance.

The terrorist attacks influenced the health care needs and frequency of treatment for people who did not enroll in the program. In the years after September 11, this group reported the highest levels of need and service use for dental and mental health services and for prescription drugs. There were significant increases in the use of emergency room and mental health services, as well as a decline in the use of traditional medicine.

The group in general showed a lack of sophistication about health insurance. For those with the most limited exposure to the U.S. health care system, employer-sponsored insurance was a foreign concept. Said one immigrant, *“My employer did not buy insurance for me. Why does he have to?”* Participants did not fully understand rules about health care programs and insurance, and often did not look beyond erroneous information received from their friends, relatives or co-workers. Consequently, very few had been proactive in pursuing health insurance.

Language barriers also limited the health care options available to this immigrant population: *“I was not satisfied and had not used the service at all because we were limited to using the clinic in Queens only. It was too far away and I did not know how to take a bus to get there. The staff in the clinic spoke English only. So I paid to see a private doctor out of my own pocket,”* said one participant.

HCP was able to overcome the lack of a sophisticated understanding of health insurance and language barriers through their simplified application process. By accepting alternative forms of documentation, and with the aid of well-informed staff members, many more individuals were able to enroll in the program.

People who were members of a union before they lost their jobs were most aware of the availability of COBRA. But most of them could not afford COBRA and chose not to participate: *“I paid \$40 for a visit and medicine,”* says one. *“I have no money. I don’t even have enough food. How can we afford health insurance? Insurance is a luxury for me.”*

A few individuals had difficulty maintaining health coverage because programs were unresponsive to their attempts to enroll: *“After September 11,”* says one, *“I had temporary Disaster Relief Medicaid. In August 2002, when I applied for Safe Horizon, they told me that I am eligible for Medicaid but there was no reply from them.”*

### ***Immediate Health Needs***

An individual’s immediate health needs also influenced the decision-making process. People with past coverage were more aware of their own health needs. They knew lab

tests were an important aspect of preventive health care, and were aware of their chronic medical conditions.

People who chose to enroll in the health program reported little change in how frequently they accessed health services. There were no changes reported in their need for prescription drugs or emergency room care. The largest change, an increase of 5.77 percent, was in the need for dental services. People who reported accessing health service more often used dental and surgical services more, but decreased their reliance on emergency rooms.

The cost of insurance and paying for health care services is a constant worry for many immigrants and low-wage workers. Many participants only visited unlicensed doctors for treatment because of their lower costs. One participant complained, *“Can’t afford the licensed doctors, very expensive.”* Another said, *“If I am sick, I go to see my private (no license) doctor because I am undocumented. My husband will go to the emergency room. He receives emergency benefits.”*

The HCP’s four health providers were the Affinity Health Plan’s Sunrise Program; the Chinatown Health Partnership at Charles B. Wang Community Health Center; the Chinatown Health Partnership at Lutheran Family Health Centers, Sunset Park; and the Union Health Center, the primary care and multi-specialty ambulatory health center providing healthcare to the active and retired members of the Union of Needletrades, Industrial, and Textile Employees (UNITE).

Drawing from their experience with employer-sponsored private health insurance, enrollees who chose the Affinity Health Plan liked the extensive network of providers, the comprehensive services covered, as well as the freedom of choice. People who selected the Charles B. Wang center were also pleased with the experience, and noted the friendly staff and good follow-up. *“Even though I missed my appointment, they followed up and reminded me to go again,”* recalled one enrollee. Enrollees in the Sunset Park program, meanwhile, cited the efforts of personalized outreach that eventually helped them choose this site. Enrollees who chose the Union-sponsored health provider were satisfied with services, but wanted a better dental plan, shorter waiting times to see a doctor and a more convenient location.

Some enrollees, however, recognized shortfalls in the HRP program, particularly in the area of limited coverage. *“First, the insurance does not cover hospitalization. Then dental*

*insurance only covers simple procedures. Bigger surgeries like implants and bridges are not covered,”* commented one participant.

## **Recommendations**

Based on these findings, the AAFNY research team developed a series of recommendations geared for public and private service providers in designing and implementing programs to serve immigrant populations.

### ***Program Design***

1. Complete a thorough needs assessment to ensure health insurance access for underserved groups in the community and to accommodate the community’s special circumstances in a culturally and linguistically appropriate manner. A community’s unique characteristics must be taken into account when implementing programs. Specifically, this can be accomplished by:
  - gathering comprehensive information about subpopulations from community-based organizations, since many are absent from formal data sources such as the 2000 Census;
  - accepting alternatives to standard documentation requirements to accommodate the cash-based nature of Chinatown businesses; and
  - increasing language access to the health care system for those with limited English proficiency and little or no prior health insurance experience.
2. Conduct comprehensive community health education campaigns to build awareness of preventive health care and available public and private insurance programs. This can be accomplished by:
  - providing long-term community education efforts focused on the benefits of health maintenance, prevention, insurance, and service providers through the use of workshops, educated frontline staff, and public service announcements; and
  - supplementing media outreach with individual contact through local community-based organizations.
3. Provide automatic enrollment, personal attention, variety of choices, and/or education on how to make simple comparisons when offering a choice in provider. Simplifying the enrollment process, providing assistance, or educating the client about choices in providers will help facilitate enrollment into health programs.

*Policy*

4. Provide continuing coverage for current program participants who have no alternatives when the program ends. To continue the efforts of the September 11th Fund at the program's conclusion, local and state governments should investigate ways to insure the dislocated working population affected by the attacks of September 11.
5. Expand health coverage accessibility by streamlining the enrollment process into government-sponsored and other health insurance programs. States should have the option of increasing accessibility to health insurance programs by streamlining enrollment, minimizing the duplication of applications, and integrating information from various program databases to maximize clients' ability to access different programs.
6. Encourage joint employer- and union-sponsored health insurance for workers in Chinatown and other immigrant communities. Major business sectors in the Chinatown community, such as the restaurant, retail and service industries, should be encouraged to follow the unionized garment industry's lead in providing employer sponsored insurance.



**LESSONS LEARNED FROM A PROGRAM  
TO SUSTAIN HEALTH COVERAGE AFTER SEPTEMBER 11  
IN NEW YORK CITY'S CHINATOWN**

**I. INTRODUCTION**

This study focused on the Health Care Program (HCP), part of the Ongoing Recovery Program (ORP) of the September 11th Fund. Implemented in August 2002, the HCP had an enrollment deadline of January 31, 2004. It provides up to 12 months of free health care coverage to workers who are not eligible for public health insurance programs and cannot afford to pay private health insurance premiums.

When it launched the HCP, the September 11th Fund expected to serve 13,000 to 15,000 individuals, mostly unemployed workers. As of November 2003, some 14,000 individuals, including enrollees and their dependents, had accessed the health care program 15 months after its inception. More than 60 percent of them spoke Chinese dialects, including Cantonese, Fuzhounese,<sup>1</sup> and Mandarin.

To qualify for the ORP, individuals had to contact Safe Horizon,<sup>2</sup> the entity responsible for program outreach and enrollment, and sign up for an orientation session. Individuals had to present qualifying documents at these sessions. Eligible participants received a card at the end of the session that let them access an array of services, including vocational classes, employment, and mental health assistance. Participants were responsible for independently enrolling in each program, including the HCP.

Through this study, the Asian American Federation sought to identify and understand the factors that had motivated eligible Chinatown workers to enroll in the HCP or to decline enrollment. Specifically, the study examined the influence of past health coverage, socioeconomic status, and proficiency in English on access, perceptions and behavior concerning health insurance and health care.

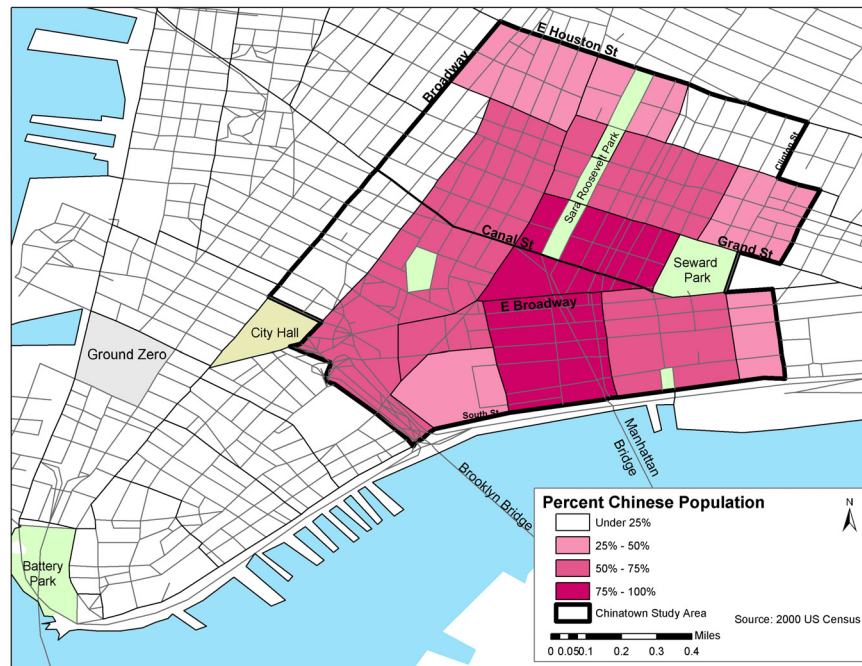
HCP was available to an immigrant enclave, one of the largest Chinese American communities in the United States (Figure 1). This unique situation offered important lessons about outreach and service to this culturally and linguistically isolated population. These lessons can be applied to future programs and public policies that benefit other immigrant communities.

---

<sup>1</sup> In this study, Fujianese refers to people who listed their birthplace as the Fujian province of China. The dialect of the province is Fuzhounese.

<sup>2</sup> Safe Horizon is a victim assistance, advocacy, and violence prevention organization serving New York City.

**Figure 1. Chinatown Study Area with Chinese Population Concentrations**



The Federation research team conducted 12 focus group sessions with a total of 94 participants.<sup>3</sup> All were of Asian descent and employed in Chinatown before September 11, 2001. This study consisted of two populations: six “enrollee” groups that were comprised of individuals enrolled in the HCP, and six “non-enrollee” groups that were comprised of individuals who had completed either none, or only half, of the two-step enrollment process.

Focus group sessions occurred in two rounds, each with three enrollee groups and three non-enrollee groups. The first round was conducted between March 19 and April 11, 2003, and the second ran from July 9 to July 25, 2003.<sup>4</sup> Enrollee focus group participants<sup>5</sup> were recruited through four service providers,<sup>6</sup> while non-enrollee participants were enlisted through community agencies or direct outreach.

<sup>3</sup> Out of 98 focus group participants initially recruited, four were deemed ineligible for the study.

<sup>4</sup> Findings reflect consolidation of the two phases.

<sup>5</sup> Focus group participants will be referred to as participants for the rest of this study.

<sup>6</sup> Enrollees who took part in the study signed up with one of the four HCP health providers able to serve Chinatown’s working population: Chinatown Health Partnership (consisting of the Charles B. Wang Community Health Center and the Lutheran Medical Center at Sunset Park in Brooklyn), Affinity Health Plan—Sunrise Program, and Union Health Center.



Both qualitative questioning and quantitative surveys were used. Participants were asked about their prior experiences with health insurance and health care, their knowledge of the HCP, enrollment experiences at Safe Horizon and health service sites, their reasons for enrolling or not enrolling in the program, and their plans for any future health coverage. Questionnaires were filled out at the conclusion of the sessions. Each session was held in Cantonese, Mandarin, Fuzhounese or English. All sessions were transcribed verbatim into English.

This report is organized in the following manner:

- Background information on the participants, including a demographic analysis, self-reported health insurance experiences, and health care behavior.
- Major findings on providers' outreach strategies, study participants' enrollment experiences at Safe Horizon and other health provider sites, and participants' plans, if any, for health care after the HCP concludes. These findings are based on focus group answers, participants' questionnaire responses, and feedback from service providers.
- A summary of lessons about providing health and social services to an immigrant community.
- Public policy recommendations based on the research findings.

The appendix section includes an extensive participant profile, a detailed methodology, and a description of participating health care providers.

To better understand factors that may facilitate or hamper an individual's health insurance and health care choices, the research team conducted Chinese-speaking focus group sessions with individuals who had enrolled with one of the four health service providers.

The HCP's four health providers were the Affinity Health Plan's Sunrise Program; the Chinatown Health Partnership at Charles B. Wang Community Health Center; the Chinatown Health Partnership at Lutheran Family Health Centers, Sunset Park; and the Union Health Center, the primary care and multi-specialty ambulatory health center providing healthcare to the active and retired members of the Union of Needletrades, Industrial, and Textile Employees (UNITE).

Other focus groups featured non-enrollees recruited by the Federation in partnership with other community organizations.

## **II. COMMUNITY AND PARTICIPANT PROFILES**

Demographic characteristics (income, education, immigration status and English language proficiency) are important influences on access to health care by an individual or a population.<sup>7</sup> Data from Census 2000 demonstrate that even before September 11, Chinatown was a neighborhood challenged by its low socioeconomic status, a condition that restricts various forms of access (financial, informational and physical) to adequate health care. While roughly one-half of the focus group participants lived outside Manhattan, their demographic characteristics generally mirrored those of the residential population captured by the census.

### **BACKGROUND: DEMOGRAPHIC PROFILE**

#### **A Census-Based Demographic Profile of Chinatown**

In 1999, the per capita income for Asians in Chinatown was only \$12,065, compared to an average New York City per capita income of \$41,887. Nearly one-third of Asian households were living in poverty, and the majority (80.7%) of poor children lived with a married couple.<sup>8</sup> More than one in three (3,762) Asian children in Chinatown lived below the poverty line, compared to the New York City average of one in ten. More than 40 percent of these families earned less than \$20,000, and more than 60 percent of Asian elderly households earned under \$15,000.

In 2000, more than eight out of ten Asians in Chinatown were foreign-born (44,125). Among the foreign-born, 48.1 percent (26,190) were not U.S. citizens. As immigrants, Asians in Chinatown faced language and educational barriers. While most (93.8%) of Chinatown's Asians speak a language other than English, the majority (58.9%) of Asians in Chinatown did not speak English "well" or "at all." Of those who were of working age (18 to 64), more than 60 percent had limited English proficiency, which increased the difficulty of obtaining jobs outside of Chinatown. Nearly 70 percent of Chinatown's Asians did not have a high school diploma, and nearly half had less than a ninth-grade education.<sup>9</sup>

---

<sup>7</sup> U.S. Census Bureau (2003); Ku & Waidman (2003).

<sup>8</sup> A household consists of all the people who occupy a housing unit. A house, an apartment or other group of rooms, or a single room, is regarded as a housing unit when it is occupied or intended for occupancy as separate living quarters; that is, when the occupants do not live and eat with any other persons in the structure and there is direct access from the outside or through a common hall. A household includes the related family members and all the unrelated people, if any, such as lodgers, foster children, wards, or employees who share the housing unit. A person living alone in a housing unit, or a group of unrelated people sharing a housing unit such as partners or roomers, is also counted as a household. The count of households excludes group quarters. There are two major categories of households: "family" and "nonfamily."

<sup>9</sup> Universe: Asian Alone Population 25 years and over (39,246).

## A Demographic Profile of Study Participants

Middle-aged females from the garment industry were one of the groups most affected by the September 11 attacks and formed the majority of focus group participants (Table 1). All of the participants worked below Canal Street or within Chinatown. Fifty-two percent lived in Manhattan, 31 percent lived in Brooklyn and 16 percent lived in Queens. The vast majority (84%) of study participants earned less than \$20,000 a year.

**Table 1. Focus Group Demographic Profile**

	E	NE	All		E	NE	All
<b>Total Participants</b>	52	42	94				
<b>Gender</b>				<b>Place of Birth</b>			
Male	33%	12%	23%	China—Canton	60%	33%	48%
Female	67%	88%	77%	China—Fujian	12%	64%	35%
				China—Hong Kong	17%	2%	11%
<b>New York Residence</b>				China—Zhe Jing	2%	0%	1%
Brooklyn	48%	10%	31%	Singapore	2%	0%	1%
Long Island	0%	2%	1%	South Korea—Seoul	2%	0%	1%
Manhattan	38%	69%	52%	Taiwan	2%	0%	1%
Queens	13%	19%	16%	United States	2%	0%	1%
				Vietnam—Saigon	2%	0%	1%
<b>Age</b>				<b>Immigration Status</b>			
20–29	2%	17%	9%	U.S. Citizen	46%	26%	37%
30–39	23%	21%	22%	Legal Resident	46%	43%	45%
40–49	40%	31%	36%	Other	8%	31%	18%
50–59	31%	26%	29%				
60+	4%	5%	4%	<b>Years in the U.S.</b>			
				0–9	35%	60%	46%
<b>Marital Status</b>				10–19	38%	19%	30%
Single	12%	12%	12%	20–29	21%	17%	19%
Married	88%	83%	86%	30+	6%	2%	4%
Widowed	0%	2%	1%	N/A	0%	2%	1%
Separated/Divorced	0%	2%	1%				
				<b>Primary Language</b>			
<b>Children</b>				Cantonese	79%	38%	61%
0	25%	14%	20%	English	4%	0%	2%
1	31%	17%	24%	Fuzhonese	2%	57%	27%
2	23%	38%	30%	Mandarin	15%	5%	11%
3	19%	19%	19%				
4	2%	5%	3%	<b>Command of English</b>			
5	0%	7%	3%	Very Well	8%	0%	4%
				Well	13%	0%	7%
<b>Highest Level of Education</b>				Not Well	46%	40%	44%
College+	17%	2%	11%	Not at All	33%	60%	45%
High School	40%	24%	33%				
Grade School	38%	60%	48%				
None	4%	14%	9%				

Note: E = Enrollees; NE = Non-Enrollees.

All but one participant was born outside the U.S., with the majority (73%) having immigrated within the last 20 years. Ninety-eight percent reported a primary language

other than English (Cantonese, Fuzhounese, or Mandarin). Most participants (81%) had a high school diploma or less and reported limited English skills (89%).

Enrollees tended to be better educated, with greater English proficiency, than non-enrollees. Non-enrollees were more recent immigrants than enrollees and were less likely to have had prior health insurance.

**BACKGROUND: TWO SUB-POPULATIONS—CANTONESE & FUJIANESE<sup>10</sup>**

Immigrants from the Canton Province on China’s southern coast have been established in Chinatown for more than 30 years. Since the 1990s, there has been a large influx of immigrants from the Fujian Province, a region just north of Canton. On the whole, the Cantonese participants in the focus groups were better educated, felt more comfortable with the English language and had lived in the U.S. longer (Table 2). More Cantonese participants were legally in the U.S. and had prior experiences with health insurance.

The Fujianese tended to be less educated, less proficient in English, and had spent less time in the U.S. Many of these recent immigrants reported that they were undocumented. In addition to their short time in the U.S. and lack of acculturation, some Fujianese faced extreme financial hardship as a result of their immigration to the U.S.<sup>11</sup>

**Table 2. Selected Demographics of the Cantonese and the Mandarin/Fuzhounese Speaking Populations**

	Cantonese = 57	Fuzhounese = 32*
<b>Education</b>		
College+	7 (12%)	1 (3%)
High School	22 (39%)	10 (31%)
Grade School	26 (46%)	15 (47%)
None	2 (4%)	6 (19%)
<b>English Proficiency</b>		
Very Well	0 (0%)	0 (0%)
Well	6 (11%)	1 (3%)
Not Well	36 (63%)	7 (22%)
Not at All	15 (26%)	24 (75%)
<b>Length of Time in the U.S.</b>		
0–9	17 (30%)	23 (72%)
10–19	20 (35%)	7 (22%)
20–29	17 (30%)	1 (3%)
30–39	3 (5%)	0 (0%)
N/A	0 (0%)	1 (3%)

<sup>10</sup> The Fujianese population includes those who reported Mandarin as their primary language but Fujian as their birthplace.

<sup>11</sup> Sengupta, (1999, March 14).

	Cantonese = 57	Fuzhounese = 32*
<b>Source of Information**</b>		
Agency	16 (28%)	15 (47%)
Word of Mouth	30 (53%)	20 (63%)
Newspaper	12 (21%)	2 (6%)
Self-referral	1 (2%)	2 (6%)
Radio	3 (5%)	0 (0%)
Other	0 (0%)	1 (3%)
None	2 (4%)	0 (0%)

\* The Fuzhounese includes those who identified their primary language as Mandarin but their place of birth as Fujian, China.

\*\* More than one choice could have been made.

### **BACKGROUND: FAMILIARITY WITH THE U.S. HEALTH CARE SYSTEM**

Enrollees had more experience with health insurance than non-enrollees, many of whom had no prior health insurance. Specifically, 74 percent of non-enrollees had no prior health coverage, compared to 29 percent of enrollees (Table 3).

**Table 3. Past Health Coverage of Participants**

Past Coverage*	E	NE	Total
COBRA	15%	2%	10%
Disaster Relief Medicaid (DRM)	29%	17%	23%
Employer-sponsored	69%	24%	49%
Medicaid	8%	12%	10%
Self-purchased	6%	0%	3%
None	29%	74%	49%

\* More than one choice could have been made.

Note: E = Enrollees; NE = Non-Enrollees.

Some participants were more familiar with health insurance and health care services than others. Those familiar with the health care system tended to be more informed about using their insurance, as demonstrated by their use of preventive care services.

People who lacked health insurance reported enduring pain or illnesses as long as possible, and delayed seeking treatment. Non-enrollee groups were less educated, spoke little English and had lived less time in the U.S., characteristics that correlate with a lack of health insurance.<sup>12</sup>

<sup>12</sup> U.S. Census Bureau (2003); Ku & Waidman (2003).

## Previous Experience with Health Coverage

EMPLOYER-SPONSORED COVERAGE WAS THE MOST PREVALENT FORM OF PAST HEALTH INSURANCE, PARTICULARLY AMONG THE UNION-AFFILIATED PARTICIPANTS.

Employer-sponsored health coverage was the most common source of insurance for both enrollees (69%) and non-enrollees (24%). The participants were generally satisfied with services under these plans. As one participant said, *“Before September 11, I had Empire, provided by my employer. The insurance covered just me. It was pretty good.”*

*“I was covered by Blue Cross insurance through the Union . . . I saw a doctor with \$10 deductible. If I needed medication, I used the Union prescription-mailing plan. It is less expensive.”*

Most people with prior employer-sponsored health insurance were covered through the Union health plan. Their long-term relationship with Union resulted in a better understanding of the American health care system. As one Union member noted, *“My family and I were covered by Blue Cross through the Union. I have this insurance for 29 years, ever since I worked as a garment worker. I am very satisfied with the insurance.”*

THE LOSS OF COVERAGE AFTER SEPTEMBER 11 MADE SOME PEOPLE SEEK ALTERNATIVE FORMS OF HEALTH COVERAGE THROUGH DISASTER RELIEF MEDICAID (DRM) OR COBRA; OTHERS REMAINED UNINSURED.

Participants who had prior insurance were more likely to seek coverage following September 11 than those without prior coverage. Temporary coverage plans such as DRM or COBRA were the most common replacements.

Union members were most aware of the availability of COBRA, but often could not afford it. Many chose not to participate: *“I have to pay \$400 per quarter for COBRA. A lot of people withdrew because they could not afford it.”*

In contrast, non-Union members primarily depended on DRM as an alternative form of health coverage. Though some had an understanding of government programs such as Medicaid, they were mostly aware of temporary options as alternate sources of health coverage. As one Affinity member stated, *“I lost the insurance benefit. I applied for temporary DRM provided by the government. I think the service was good in general. I want to renew my DRM.”*

PARTICIPANTS WITH PAST HEALTH INSURANCE COVERAGE WERE MORE LIKELY TO HAVE LEARNED ABOUT PREVENTIVE CARE THROUGH THEIR EXPOSURE TO THE HEALTH CARE SYSTEM.

Although experiences with health insurance varied, those with past coverage were more aware of their own health needs. They were able to view lab tests as an important aspect of preventive health care and were aware of their chronic medical conditions. As one participant said, *“I have high blood pressure, high cholesterol, and osteoporosis, and the clinic paid for the medication to treat these conditions.”* These participants were better able to evaluate the coverage provided by the September 11th Fund, often comparing its value to their prior insurance.

### **Common Barriers to Health Coverage**

FINANCIAL LIMITATIONS: UNINSURED PARTICIPANTS EXERCISED CRISIS-MODE UTILIZATION.

Many uninsured participants faced a barrier common to all working poor immigrants: they simply could not afford health insurance. As one participant said, *“It costs hundreds to see a doctor and I don’t even get paid that much in a month.”* People avoided the doctor as long as possible, turning first to medication and then waiting to see if symptoms would disappear on their own. Many reported waiting until their situation was urgent before seeking care: *“I did not have health insurance. I only had the flu. And I took over-the-counter medication. If I take the medicine for one or two days and I am still in pain, I know I have to see a doctor.”* Another uninsured participant reported, *“If we don’t notice any big problems, we wouldn’t regularly go to the doctors.”* These people did not have serious health problems and hoped their health would remain sound.

*“I paid \$40 for a visit and medicine. I have no money. I don’t even have enough food. How can we afford health insurance? Insurance is a luxury for me.”*

When forced to see a doctor, participants relied on community safety nets such as government clinics with reduced fees or emergency rooms. Many people were drawn to unlicensed doctors because of their lower costs. Says one, *“I can’t afford the licensed doctors, very expensive.”* Another explains, *“If I am sick, I go to see my private (no license) doctor because I am undocumented. My husband will go to the emergency room. Since he is in the emergency room, he receives emergency benefits.”*

The cost of care limited choice of health services and sometimes forced people to forgo medical care. Says one participant, *“Once my eyes weren’t good so I went to a hospital to a licensed doctor and they told me that it would cost a hundred something to get it checked. I just left*

*and didn't get it checked. Forget it!"* Given a choice of public hospitals or self-payment mechanisms, participants often went without care because of the expense.

CONFUSION: PARTICIPANTS WERE UNCERTAIN ABOUT THEIR ELIGIBILITY FOR THE AVAILABLE PUBLIC INSURANCE PROGRAMS.

Previously insured participants were confused by their disjointed experiences with Union and government-related programs. As one individual described, *"I had Local 23-25 insurance for a short period. But that was too expensive . . . They told me I am no longer eligible and I have to pay for my own. I did not know whether I am eligible for September 11 insurance."*

A few participants have had difficulty maintaining health coverage because programs were unresponsive: *"After September 11, I had temporary DRM. In August 2002, when I applied for Safe Horizon, they told me that I am eligible for Medicaid but there was no reply from them."*

With haphazard exposure to various programs, many participants were confused by eligibility requirements and often could not distinguish between government and private programs.

CULTURAL FACTORS: HEALTH CARE BEHAVIOR WAS INFLUENCED BY LANGUAGE AND OTHER CULTURAL FACTORS.

The primary language for 98 percent of the participants was a Chinese dialect. Both language and cultural factors influenced an individual's decisions about accessing health care.

Language limits the health care options available to the participants. Explains one participant: *"I was not satisfied and had not used the service at all because we were limited to using the clinic in Queens. It was too far away and I did not know how to take a bus to get there. The staff in the clinic spoke English only. So I paid to see a private doctor out of my own pocket."* For this participant, language limitations reduced the number of conveniently located medical facilities. Another non-enrolled Fujianese participant stated, *"Since we don't know English, we go to Fujianese doctors."*

Cultural factors that affect health care behavior include reliance on traditional remedies and cultural norms regarding treatment. Many participants reported that they rely on Chinese medicine before turning to doctors. The participants had a general tendency toward crisis-mode utilization, often delaying treatment because of the cost.



These factors delayed their entry into the formal health care system until absolutely necessary.

*“Only when it gets serious, that’s when we go to see a doctor. Usually we just take medicine we brought from China.”*

CULTURAL ISSUE: IN THE PAST, MANY FUJIANESE, PARTICULARLY THE NON-ENROLLEES, HAD BEEN DISCOURAGED FROM LEARNING ABOUT AND APPLYING FOR AVAILABLE GOVERNMENT PROGRAMS.

Fujianese participants expressed a sense of hopelessness about acquiring government-sponsored health insurance because of previous failed attempts. Many Fujianese workers had been discouraged from getting health insurance, and many did not understand its value. Their demanding work schedules prevented them from taking the time to learn more about government programs. For those with the most limited exposure to the U.S. health care system, employer-sponsored insurance was a foreign concept: *“My employer did not buy insurance for me. Why does he have to?”* asked one individual.

PARTICIPANTS DID NOT FULLY UNDERSTAND RULES AND OFTEN DID NOT LOOK BEYOND ERRONEOUS INFORMATION PROVIDED BY THEIR FRIENDS, RELATIVES OR CO-WORKERS. CONSEQUENTLY, VERY FEW PROACTIVELY PURSUED HEALTH INSURANCE.

Generally, enrollees had more exposure to the health care system than non-enrollees. The degree of exposure appears to influence decisions to seek health insurance. People with more positive experiences were more likely to seek coverage, while those with little or no experience did not understand the value of health insurance, did not seek information about available programs, and did not know how to select insurance. People with more positive experiences were more proactive in seeking services. Those who had negative experiences were hesitant about seeking coverage outside their employer-sponsored plans.

### **BACKGROUND: REPORTED HEALTH CARE NEEDS AND SERVICE USE**

In this section, we discuss how people felt their health needs changed in the periods before and after September 11. Then we discuss changes in the frequency with which they accessed health services.

Among participants who reported needing medical services, dental, prescription drug coverage and primary care services were identified as both the most commonly needed and most commonly used services. This was true for the periods before and after September 11.

In general, people reported that their health care needs did not change by more than 5 percent before or after the attacks. In four categories, however, there were pronounced changes in service utilization. Participants reported increases in the use of

emergency rooms (+20%) and mental health services (+16.11%). But there was a decline in the use of acupuncture (-22.84%) and Chinese medicine (-12.71%).

CHINESE MEDICINE AND ACUPUNCTURE PLACED FOURTH AND FIFTH IN THE PARTICIPANTS' RANKING OF MOST-NEEDED MEDICAL SERVICES.

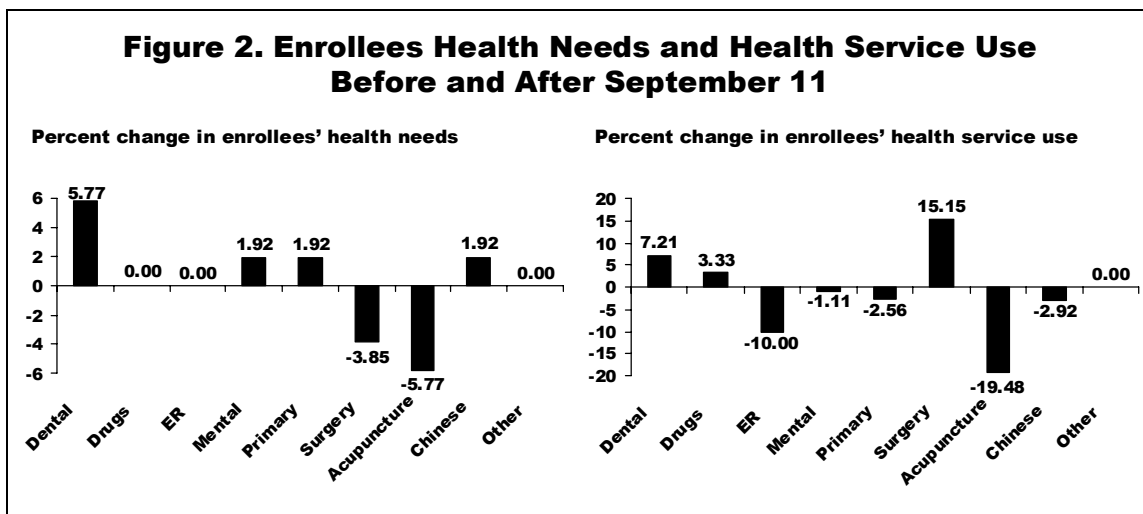
Reflecting cultural preferences, participants reported a need for Chinese medicine and acupuncture. Non-enrollees had a stronger preference for Chinese medicine than enrollees.

Before and after September 11, both the change in need and health service use for Chinese medicine remained within three percentage points for the group of enrollees. But non-enrollees reported large decreases in need and health service use of Chinese medicine. Both groups reported a decrease in the use of acupuncture, with its use by non-enrollees decreasing more. The reasons for the declining use of cultural medicine are uncertain, but both Chinese medicine and acupuncture continue to have a strong influence on health care behavior.

### Needs and Usage Before and After September 11

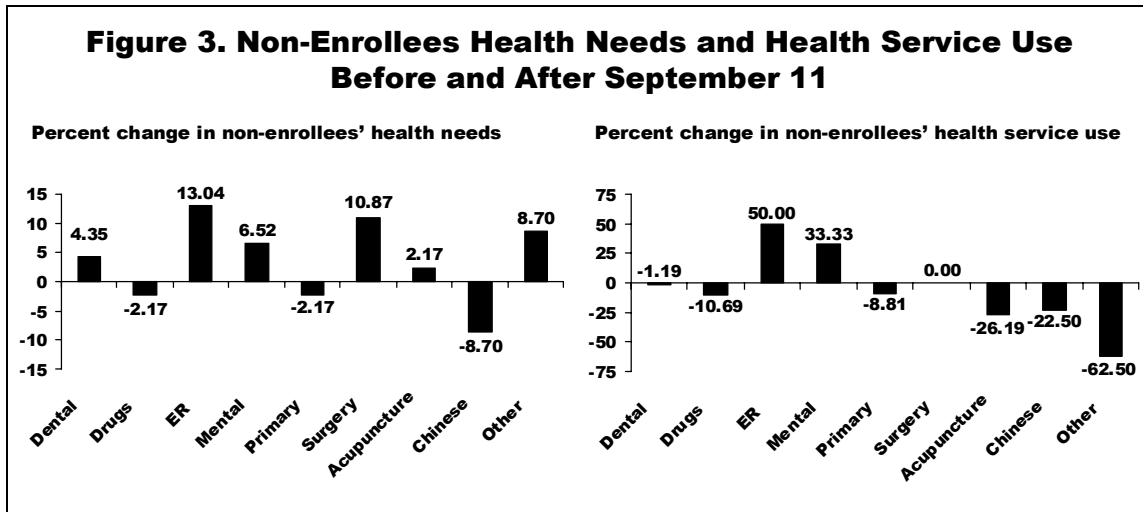
ENROLLEES REPORTED MORE CONSISTENT HEALTH CARE NEEDS AND USE.

Enrolled participants reported little change in how frequently they accessed health services. There were no changes reported in their need for prescription drugs or emergency room care (Figure 2). The largest change, an increase of 5.77 percent, was in the demand for dental services. People who reported accessing health service more often increased their use of dental services (+7.21%) and surgical services (+15.15%), but decreased their reliance on emergency rooms (-10%).



## NON-ENROLLEES REPORTED GREATER VARIATION IN HEALTH CARE UTILIZATION.

The terrorist attacks influenced the health care needs and frequency of treatment for people who did not enroll in the HCP. In the years after September 11, this group reported the highest levels of need and service use for dental and mental health services and for prescription drugs (Figure 3). There were significant increases in the use of ER and mental health services, as well as a decline in the use of traditional medicine.



September 11 had more of an impact on the non-enrollee group than on the enrollee group. This reflects the vulnerability of the non-enrollee group, which is comprised of a high percentage of recent immigrants who are poorly educated and speak little English. This group had less exposure to health insurance; was more dependent on crisis-mode access to health care; and was more reliant on cultural medicine such as acupuncture and Chinese medicine. With these differences in mind, we next turn to the HCP.

### III. MAJOR FINDINGS

#### OUTREACH

Multiple agencies were involved in the ORP, and while their outreach efforts varied all were fairly comprehensive.

Safe Horizon partnered with community-based organizations and leaders within the Chinatown community, guided by the belief that the community would be more receptive to information from a trusted source. The four service providers engaged in direct outreach, attempting to provide information about the program directly to individuals who might be eligible. Union was able to focus its outreach on its membership

database, resulting in the highest enrollment. The others engaged in a variety of activities, including press conferences, street fairs, public service announcements, newspapers, magazines, targeted mailings and flyers (Table 4).

**Table 4. Sources of Information for Participants**

Source*	E	NE	Total
Chinese Language Newspapers	21%	7%	15%
Chinese Language Radio	10%	0%	5%
Community Agencies	31%	36%	33%
Self-referral	4%	2%	3%
Word of mouth	50%	64%	51%
Other	0%	5%	2%
Don't Know	0%	5%	2%

\* More than one choice could have been made.

Note: E = Enrollees; NE = Non-Enrollees.

### Word-of-Mouth Outreach

PARTICIPANTS RELIED HEAVILY ON TRUSTED FRIENDS, FAMILY OR CO-WORKERS FOR INFORMATION.

Word-of-mouth was an important source of information. Fifty percent of enrollees and 64 percent of non-enrollees reported learning about the program through friends, family members or co-workers. These sources were believed to be reliable and

often were the only source of news about the program. As one individual said: *“I do not usually read the newspaper, watch television or listen to the radio. The most effective outreach method is through sharing experiences among friends.”*

*“I got this news from my good friend. If not from my good friend, I would not go.”*

All four service providers cited word-of-mouth as an effective means for outreach. As one administrator commented, *“We had begun with press conference, newspaper, magazine and radio ads in Chinese press, but the most effective was direct outreach and quality of service in enrollment that led to positive word-of-mouth advertising.”*

For many participants, especially the non-enrollees, the loss of jobs following September 11 affected their social and economic resources. Prior to September 11, some reported relying solely on co-workers for information. Without a job, many lost their primary channel for news. *“After September 11 I stayed at home most of the time,”* said one participant. *“I did not see many friends. I read the newspaper every day but did not notice ads about this program. It was only when I saw a friend who was on her way to apply, so I went with her.”* Without interaction among co-workers, people received news irregularly.

*“I only heard this kind of news from my co-workers. Now that we are unemployed, how am I going to get the news?”*

## Other Outreach Methods

THE OUTREACH EFFORTS OF VARIOUS AGENCIES, WERE ALSO IMPORTANT TO ENROLLING PARTICIPANTS.

About one-third of participants learned about the program through a community agency. Personalized attention from an agency helped overcome confusion and misunderstandings, and often resulted in a successful enrollment. As one participant recalled: *“I happened to be passing by CCBA on a Sunday. There was a health fair, so I went into the basement and talked to someone about September 11 health insurance. The Chinese Staff and Workers’ Association explained clearly and helped with my application.”*

MASS MEDIA HAD LIMITED EFFECTIVENESS IN REACHING THE COMMUNITY, BUT WAS MORE INFLUENTIAL WITH CERTAIN SEGMENTS OF THE POPULATION.

For the Cantonese population, which comprised about one-third of the enrollees, newspaper and radio advertisements had some effectiveness in spreading information. These participants cited newspaper or radio as their information source. The newspaper and radio advertisements were successful at raising general awareness of the program. But they also could be ineffective, as one participant illustrated: *“The radio may have talked about September 11 insurance, but I’m not sure. I listen to the radio because the factory has radio. I heard some but not all the details.”* Outreach was only effective if all significant details could be accurately conveyed.

*“I read about September 11 insurance through the newspaper . I also learned about it from AM 1480 radio. They are a wonderful station to outreach to people. Through them, I learned about the importance of health insurance.”*

The Fujianese population was at a disadvantage in learning about the program because it was hampered by limited education, fears related to their undocumented status, and limited proficiency in Cantonese, Mandarin and English. Most Fujianese learned about the program through word-of-mouth (63%) or agency outreach (47%) but only 2 percent learned about the program through newspapers (see Figure 3). Consequently, the Fujianese were forced to rely on personal contact to receive the news. As one service provider stated: *“The Cantonese are exposed to more media. The media is accessible to them. People who speak Fujianese aren’t exposed to much media.”*

The Fujianese participants expressed a sense of helplessness because *“we do not know English. We have to wait for someone who knows English to explain things to us. Life is difficult.”*

## **Lack of Complete and Accurate Information**

MANY ENROLLEES DID NOT KNOW THE DETAILS OF THE PROGRAM OR THE FULL ARRAY OF SERVICES OFFERED BY THE ORP UNTIL ARRIVING AT THE SAFE HORIZON ORIENTATION SESSION.

Many enrollees applied for the ORP with the intention of using employment and job training services, and did not know about the health care benefits. A lack of previous experience with health insurance made it difficult to value health coverage in comparison to the immediate benefits of a job training program or English classes. *“Initially I got my Safe Horizon card for the purpose of studying English,”* says one participant. *“I did not pay attention at the orientation session and did not quite understand what they said about other programs.”*

*“I used to think I am young, I will not get sick. So, I got Safe Horizon primarily to attend job training classes. However, when they explained to me the importance of health insurance, they convinced me that it is good to have as a preventive measure.”*

Safe Horizon provided information about the health care program at every orientation, but some enrollees did not absorb that information. One enrollee indicated that he was not even informed about the health care program at his Safe Horizon orientation: *“At the orientation, I was not informed about different choices of health insurance. . . . At that time, they told me I have to pay COBRA at \$50 a month for a period of several months.”*

NON-ENROLLEES CONFUSED THE ORP HCP WITH DRM OR OTHER PUBLIC PROGRAMS, AND SIMPLY ASSUMED THEY WERE INELIGIBLE.

Although non-enrollees had heard about various health care programs, many automatically assumed they would be ineligible. This was a common sentiment among undocumented immigrants, who are ineligible for most government programs. These people associated the HCP with other public programs such as DRM or Family Health Plus.

Some people were deterred from applying for the ORP because of their perceptions of these other programs. The proliferation of incorrect information also was particularly damaging for non-enrollees because of their heavy reliance on word-of-mouth for information.

There are several significant points to make about outreach. Word-of-mouth was the most important method of outreach, followed by community agencies and newspaper ads. The source of information influenced whether an individual sought additional information about the program. The absence of information that could be understood by the Fujianese population hindered outreach to that community. A lack of understanding about health insurance prevented some participants from getting accurate information

about the ORP. When uninsured people who had no immediate health care needs were exposed to some information about the program, they did not regard health insurance as a topic worth learning more about.

## **FINDINGS: ENROLLMENT AT SAFE HORIZON**

Enrollment at Safe Horizon generally went smoothly. Community agencies often provided personal assistance to facilitate enrollment, as did service providers, to a lesser extent. When participants did have difficulty enrolling, the primary cause was the challenge of obtaining documentation. Non-enrollees had been discouraged from enrolling because of difficulties in obtaining documentation, and a lack of knowledge about the program.

### **Importance of Proper Documentation**

#### ENROLLEES EXPRESSED SATISFACTION AT THE EASY ENROLLMENT PROCESS AT SAFE HORIZON

Participants enrolled easily when they were adequately prepared with the proper documentation. *“The application was quick because I had all the documents ready and the documents were authentic,”* noted one participant. Churches and social service agencies often provided assistance that proved critical to the enrollees’ preparedness and ability to complete the application. One enrollee who had no trouble receiving her Safe Horizon card recalled, *“It was easy to get my September 11 insurance. Before the interview, the Chinese Staff and Workers’ Association helped me obtain additional documents because my job was paid in cash.”* Enrollees were quite pleased with the quick receipt of their Safe Horizon white cards.<sup>13</sup>

#### OBTAINING THE NECESSARY DOCUMENTATION WAS ALMOST IMPOSSIBLE FOR SOME, FORCING PARTICIPANTS TO RETURN SEVERAL TIMES IN AN ATTEMPT TO ENROLL.

The enrollment process was difficult for non-enrollees, particularly garment factory workers. There were two significant impediments to obtaining documentation required for enrollment: the cash-based Chinatown economy, and the inaccessibility of former employers that had shut down their businesses as a result of September 11. One participant tried to track down her former boss to obtain proper documentation: *“When they asked for proof of employment, I went to look for my ex-boss. But he sold his factory so how can I get the proof? The factory closed down!”*

---

<sup>13</sup> The Safe Horizon white card is given to all eligible participants at the end of the information session, which verifies access to available resources. There is a 7-day interim period where documents are verified.

This problem was particularly challenging for the Fujianese. Their case manager noted, *“the owners of these factories do not hire unionized workers, and when the factories shut down, they are not placed onto an official list. It is very difficult for these individuals to prove the address of the company when the owner is unwilling to help them.”*

*“I applied three times. The first time, I had to go back for an employment record to prove that I worked in Chinatown before September 11. The second time, I had to go back to get the last paycheck from my employer. The third time, they finally approved me.”*

Problems in obtaining documentation made enrolling at Safe Horizon difficult for several enrollees. *“I applied three times,”* said one. *“The first time I had to go back for an employment record to prove that I worked in Chinatown before September 11. The second time, I had to go back to get the last paycheck from my employer. The third time, they finally approved me.”*

Although a few enrollees were able to overcome problems in acquiring documentation on their own, community agencies also played a critical role in helping individuals enroll. One person only succeeded in getting the necessary documentation after church staff intervened: *“When I applied, my employer was not willing to write documents for me. It was only when the staff at the church explained to my employer that he was finally convinced to write an employment letter. That got me approved.”*

### **Lack of Awareness and Accurate Information**

NON-ENROLLEES WERE THWARTED BY INEFFECTIVE OUTREACH METHODS AND INACCURATE INFORMATION.

Many Fujianese did not enroll in the HCP because they were unaware of the program or did not have correct information that would have lead them to enroll. As one explained, *“If I had known that I could apply even if I am undocumented, I would’ve applied a long time ago.”* Another expressed uncertainty about the application process, saying, *“we don’t even know where to get the applications.”* Others had limited information about the program and drew erroneous conclusions about their ability to enroll. Another participant was influenced by fear: *“We’re afraid that we might be arrested because we are undocumented.”*

Many non-union members did not enroll in the HCP because of confusion and misinformation about its relation to other health programs, particularly DRM and FHP. One individual described not making *“use of DRM because I heard that I cannot see the doctors more than 10 times. I also heard that I would not be eligible for September 11 insurance if my savings are more than \$3,000. So I dare not apply for September 11 insurance. I dare not see any doctor.”* Another said, *“No, don’t know about the program. We just thought it was Family Health*



*Plus.*” Many assumed the ORP HCP was similar to the insurance programs with street outreach: *“The stands are everywhere in the streets of Chinatown. They’re saying that if you’re undocumented and you don’t have any kind of paperwork, you can’t apply.”*

Some people who knew about other government programs actively rejected the HCP. They chose not to enroll because they opted to pursue the long-term coverage afforded by public health programs instead of the time-limited coverage of the HCP.

OTHER NON-ENROLLEES WERE DISCOURAGED FROM ENROLLING BECAUSE OF RUMORED LONG WAIT LINES IN DOCTORS’ OFFICES, DELAYS IN RESPONSE OR NO RESPONSE AT ALL.

Many participants enrolled because of the program’s positive reputation, but others rejected the program because of the negative things they had heard about it. As one person said, *“It is easy to get September 11 insurance but I just don’t want it. It is such a long wait. The doctors have too many patients.”*

*“Even if I had September 11 insurance, I don’t think it would be good. The appointment times would be too long. If one gets sick, he will not get immediate care. I would rather pay for a private doctor out of my own pocket.”*

Other participants had problems getting a response from either Safe Horizon or a provider. *“It is the problem of September 11 health insurance. They haven’t given me a reply,”* said one. Another stated, *“six months passed and still there is no news.”*

## **FINDINGS: FACTORS IN CHOOSING A PROVIDER**

Participants talked about the process of choosing a health provider. Overall, enrollees based their choice on such criteria as reputation, personal attention and comprehensive services.

There was wide variation in how much enrollees knew about the providers. Some knew about all four providers. Others had little or no understanding of health provider options. As one participant recalled, *“I don’t remember many choices.”*

Others found it too difficult to make educated decisions: *“Because I had no insurance before, I did not know how to compare.”* Such participants were forced to rely on information provided by a friend or staff member of the health provider.

## **Factors Involved in Choice of Provider**

### ***Charles B. Wang Community Health Center—Reputation***

As one of the oldest health providers in Chinatown, Charles B. Wang was chosen primarily for its positive image, although its location, Chinese-language capabilities, and comprehensive services also were important factors. One Charles B. Wang participant stated, “*Safe Horizon told me how to apply. The staff told me that Charles Wang provided the most complete services. It was like ‘one dragon service.’ Since I work in Chinatown, I think Charles Wang Center is the best choice.*”

*“The staff told me that Charles Wang provided the most complete services. It was like ‘one dragon service.’”*

### ***Union Health Center—A Seamless Process***

Union members had a modified enrollment process. For those who attended orientation sessions sponsored by both Safe Horizon and Union, enrollment in the HCP was automatic. Most were enrolled without even realizing that their health insurance was being paid for by the ORP. This seamless process allowed Union members to continue enjoying health insurance benefits with which they were familiar. This plan had low premiums at a time when finances were strained. “*When I was unemployed, I had no Union insurance so I got September 11 health insurance. It is an extension of my Blue Cross for one year.*”

*“I got September 11 health insurance. It is an extension for my Blue Cross for one year.”*

### ***Chinatown Health Partnership, Sunset Park—Personal Attention***

Enrollees in the Sunset Park program were attracted by its personalized outreach efforts. As one Sunset Park participant described: “*Mrs. Aina Chen made an appointment for me. In two hours, she explained all the benefits to me. She helped me fill out forms and walked me around. The clinic is near my home. The facilities are good. The place is clean. Mrs. Chen is also very responsible.*”

*“The environment, the facilities, and the plan coverage were nice. It was most suitable to me. The location is convenient. The service manager is good. So I chose the Chinatown Health Partnership.”*

### ***Affinity Health Plan—Comprehensive Services***

People who were experienced with employer-sponsored private health insurance often chose Affinity. These enrollees were better educated and had higher incomes, and were capable of navigating the paperwork required by a managed care organization. They liked the extensive provider network, the comprehensive services and the freedom of choice. “*At the*

*“Affinity has more choices, more doctors, more dental coverage, more medicine coverage, etc. I can have a wider range of services.”*

orientation, they introduced the services provided by organization and health providers. Affinity has more choices, more doctors, more dental coverage, more medicine coverage, etc. I can have a wider range of services,” said one enrollee.

#### SOME CHOSE A PROVIDER BECAUSE OF THE EASE OF ENROLLMENT.

In some cases, enrollees changed their mind during the process of enrolling at a health center because of the provider’s poor customer service. People would reject a center that did not immediately respond to their needs and questions. One participant commented, *“At first, I chose Affinity. I was given a big file of paper. The salesman did not answer most of my questions. I was only given a bunch of phone numbers. I thought the service was no good . . . Mrs. Chen of Lutheran explained Sunset Park insurance to me. She told me how to change from Affinity to Sunset Park. She explained clearly. So I switched to Sunset Park.”*

In the absence of additional information or a better understanding of how to choose insurance plans, responsiveness and personal attention became deciding factors. The experience of one person who contacted multiple providers was typical: *“I was given three choices. I called them all. Only one plan had staff available to answer questions and she filled in forms for me.”*

#### **FINDINGS: EXPERIENCE ACCESSING SERVICES**

Enrollees were questioned about their experiences with accessing services. People were generally satisfied with the health services they received through the HCP. Some expressed concerns about limited coverage, but were satisfied with the friendly staff. More recent enrollees voiced concerns about long wait times. Some reported waiting several weeks for an appointment, which they considered unacceptable.

#### **Importance of Preventive Care**

##### PARTICIPANTS WHO USED HEALTH INSURANCE LEARNED THE IMPORTANCE OF PREVENTIVE CARE.

Some people who had health insurance continued to delay seeking treatment. But when they visited doctors who could explain the importance of preventive care, some patients learned how to make better use their health insurance. One shared how her experiences with health insurance deepened her understanding of Western health care: *“I had never used insurance [before]. Now, I had a whole body check up. I was prescribed a cholesterol-lowering medication . . . During my second visit, I told Dr. Shen that the drug was too expensive. Dr. Shen convinced me that it is better to use an expensive drug now than to get a more serious illness later. I paid \$200 for the drug.”*

## Positive Images of the Health Services

UNION PARTICIPANTS WERE SATISFIED WITH THEIR SERVICES, ALTHOUGH THEY SUGGESTED A BETTER DENTAL PLAN, SHORTER WAITING TIMES AND A MORE CONVENIENT LOCATION.

For the most part, Union members reported satisfaction with Union services. Said one member, *“I wish I could continue to use the health care center. The services and manner of the doctor and staff are good.”* A few participants suggested improvements. Some wanted dental coverage. Another talked about the location: *“It would be even better if the Union health center moved to Chinatown. I could save \$3 in transportation costs. The health center is uptown.”* One individual expressed concerns about eligibility: *“I was worried about running out of insurance. The private doctor that I saw did not trust that I had valid insurance. They made me pay first and then reimbursed me after they received their share from the insurance company.”*

*“I have no problems. The service is good. The day before the appointment, the staff called to remind me.”*

AFFINITY PARTICIPANTS FELT COMFORTABLE WITH THEIR NEW PROVIDER, BUT SOMETIMES FELT CONSTRAINED BY THE NETWORK OR CONFUSED ABOUT DIFFERENCES IN PROVIDERS.

There were only a few Affinity participants, but they all understood that the current coverage was meant to tide them over until they got insurance from another source. One summarized, *“I have actually seen the doctor only one time. It was pretty easy to set up an appointment. The location was fine. I went for a general body check up.. It was like all the other health care programs. You select a primary health care physician [from] a list of doctors and specialists. I do want a clearer classification, more up to date, and better network to choose from. So far, I guess the doctor and prescription have been fine.”*

*“It was pretty easy to set up an appointment . . . . So far, I guess the doctor and prescription have been fine.”*

SUNSET PARTICIPANTS WERE GENERALLY SATISFIED WITH SERVICES, ALTHOUGH SOME COMPLAINED OF LONG WAIT TIMES.

Many Sunset participants cited dissatisfaction with the long wait and multiple visits required to receive care. Some expressed dissatisfaction with the time it took to get an appointment: *“If I were sick, I would wait for a few days before I made an appointment. If I made an appointment, they would make me wait for another week. By that time, the pain would go away.”*

*“The service I receive through this insurance is normal. I waited for one week for an appointment. It was longer than expected. My child had a cough. The doctor was good. The medicine was good.”*

Participants complained about long wait times in the waiting room: *“The clinic is too busy. There are too many patients and too few doctors. Sometimes the clinic is so full that a lot of patients have to stand and wait. I don’t have to wait if I go to a private doctor. I did not expect to wait so long when I enrolled.”* One participant expressed her distrust of the system: *“They made me come several times, to make more money.”*

CHARLES B. WANG PARTICIPANTS GENERALLY FELT SATISFIED WITH THEIR SERVICES, ESPECIALLY WITH FOLLOW-UP AND FRIENDLY STAFF. BUT THEY ALSO COMPLAINED OF DELAYS AND WAIT TIMES.

Overall, enrollees expressed positive experiences in accessing services at Charles B. Wang. In particular, they noted that the services are satisfactory, with good follow-up and friendly staff.

One individual was surprised at the quality of the service: *“I had September 11 insurance for 1 month. I had a body check up. The service was good. I had a follow-up 3 weeks later. I don’t think the appointment time is too long. I did not have big expectations from this September 11 insurance.”*

*“Even though I missed my appointment, they followed up and reminded me to go again.”*

Others recognized shortfalls of the program, particularly in the area of limited coverage. As one participant expressed her concern, *“First, the insurance does not cover hospitalization. Of course I do not want to be so ill to be hospitalized, but it would be better if they also cover hospital, too. Then dental insurance only covers simple procedures. Bigger surgeries like implants and bridges are not covered.”*

Enrollees were also concerned about long waits, both to schedule an appointment and in the office. One participant said, *“Once I needed to extract a tooth because it ached so much. They could not give me an early appointment. I had to wait one month. So I paid out-of-pocket to extract my tooth.”*

Overall, participants were pleased about their experiences accessing health services. Most appreciated the convenient location, high quality customer service and personal interactions.

There were some concerns, however, about the lack of hospitalization coverage and more comprehensive dental coverage. Participants were primarily concerned about the perceived delays in getting appointments, as well as perceived long wait times in the waiting room. Many participants who heard about the difficulties others had with long

waits would try to delay treatment in the hope that their pain would go away. In some cases, people would wait until their pain was severe before trying to make an appointment, and then they expected immediate treatment.

### **FINDINGS: FUTURE PLANS FOR HEALTH COVERAGE**

Nearly all of the focus group participants wanted health coverage, but many continued to face financial problems and language barriers, or were ineligible for public programs. All of the enrollees wanted HCP to continue. When it ended, Union participants wanted to continue with Union. Sunset and Charles B. Wang participants were interested in pursuing government programs, although many recognized they were ineligible for them. These people said that they would go uninsured. Affinity participants hoped for private health insurance in the future.

Non-enrollees mostly expressed a desire to enroll in the HCP or to explore other public programs. Many Fujianese non-enrollees said that they would enroll if they were assisted with the process.

Many participants expressed a deepened understanding of government health programs. Some recognized their ineligibility for government health programs, but others erroneously believed they were eligible.

### **Increased Awareness and Government Programs**

MANY ENROLLEES LOOKED FAVORABLY AT GOVERNMENT PROGRAMS AND HOPED TO OBTAIN HEALTH CARE THROUGH THEM.

Most non-union enrollees held favorable views about government programs. Many hoped to obtain health care through them. *“The U.S. government has been good and kind to provide September 11 insurance,”* said one. *“I’d consider some other government insurance if I ever become unemployed when September 11 insurance expired.”*

*“If this insurance does not cover hospitalization, I am worried. I will apply for family health insurance. After joining this Safe Horizon program, I understand more about government insurance. I did not know much at first.”*

Other enrollees noted a greater awareness of governmental programs as a result of the HCP. Although they were unsure which program was best suited to them, they hoped to obtain government-sponsored health insurance in the future. As one enrollee expressed, *“I will only consider government insurance.”* Although many hoped to get such insurance, few had concrete plans for pursuing it.

Many enrollees understood the stringent eligibility requirements of government health care programs. One wanted to be unemployed to meet those requirements, or to find work with employer-sponsored insurance: *“I would rather not work to attain government insurance or work in places where insurance is provided.”*

However, many others still did not know how to determine eligibility or how to enroll in these programs. *“After I attended the Safe Horizon orientation, I understood more about other government insurance but not in very much detail,”* said one. In fact, many people were ineligible for government programs but still expressed interest in pursuing public health insurance.

#### NON-ENROLLEES WANTED TO EITHER ENROLL IN A GOVERNMENT HEALTH INSURANCE PROGRAM OR LEARN MORE ABOUT THEIR OPTIONS.

Non-enrollees wanted to pursue government coverage before considering the time-limited ORP. If other options did not work out, they would then seek private insurance, but only if their incomes were higher. Otherwise, they would do without insurance. *“Yes, I have changed my mind after this focus group discussion,”* said one non-enrollee. *“I will apply for DRM renewal. Then I will apply for September 11 insurance.”*

*“I may be eligible for Medicaid. I am unemployed. Even though I have no residential status, I think I am eligible. The problem is that I don’t know English.”*

Most non-enrollees hoped to be eligible for health insurance through government programs. People who were ineligible said that they would either spend-down to be eligible for the programs or go uninsured. The cost of private insurance was too high given their meager incomes. *“If September 11 insurance ends and I am still unemployed, I think I may be qualified for FHP. Even if I have a job, I would rather lower my income to get FHP. I hope the government raises the upper income threshold of FHP,”* said one.

*“I will not buy private insurance. Why? I do not have work and I do not have money. I don’t even have money to buy food. How can I afford health insurance?”*

#### **Employer-Sponsored Health Insurance**

#### UNION ENROLLEES EXPRESSED A STRONG DESIRE TO CONTINUE COVERAGE BUT BELIEVED THAT THEIR ONLY OPTION WAS UNION HEALTH INSURANCE.

Union enrollees placed a higher priority on health insurance than other participants. Union members also had extensive exposure to health insurance. *“The primary purpose of work is to have health insurance, no matter how low the pay is,”* said one

*“I cannot live without health insurance. I must have coverage.”*

Union enrollee. Added another: *“If I have work, I’ll have Union insurance. If I do not have a job, I will apply for Family Health Plus at one of the street stands.”* No other groups expressed the view that health insurance is a necessity. Union members all wanted to continue with Union coverage.

## **Alternatives**

FACED WITH FEW ALTERNATIVES, SOME ENROLLEES PLANNED TO DO WITHOUT INSURANCE.

A few enrollees mentioned their options included forgoing health insurance. Some who expected to become uninsured talked about maintaining a healthier diet to avoid the financial burden of health care. *“If I have no insurance, I will be careful not to get sick. I would not eat oily stuff to prevent high cholesterol,”* said one.

Another felt insurance was unnecessary for healthy people: *“I did not have insurance before. If the September 11 insurance ends, I think I will go without insurance. I am still healthy. My family members are very healthy too . . . . The fact that I have September 11 insurance now has not changed my mind about insurance.”*

The HCP was intended to be a short-term safety program, but in reality, many participants had few alternatives.

MANY NON-ENROLLEES SAID THEY WERE INTERESTED IN PREVENTIVE HEALTH SERVICES, BUT WITHOUT INSURANCE THEY WOULD CONTINUE TO DELAY ACCESSING CARE AS LONG AS POSSIBLE.

Non-enrollees that knew they were ineligible for government programs generally delayed seeking treatment. Several participants talked about living with pain and sickness out of necessity. One non-enrollee acknowledged the risks of living without health insurance: *“If there is any big illness, that’s it, we lie down and sleep [die] and if you’re not ill then we endure as much as possible.”* Another complained about the expense of accessing needed care: *“Where do you have that kind of money to see a doctor? When you are really sick and coughing terribly for months, you just buy some medicine and hope it gets better, if not you just endure it till it gets better.”*

*“Where do you have that kind of money to see a doctor? . . . If I have insurance I would go to get a shot or two and it will all get better. If you don’t have insurance . . . then you have to pay \$180. I won’t go then.”*

One previously-insured participant talked about how insurance promoted preventive care: *“To see a doctor, it was free. I wasn’t worried. I have diabetes, high blood*



*pressure, heart attack, and I learned all about it that year. If I didn't go see a doctor, I wouldn't know I had all of those illnesses."*

### **Interest in September 11 Health Care Program**

A FEW NON-ENROLLEES WERE UNCONVINCED ABOUT THE MERITS OF INSURANCE. MANY WERE INTERESTED IN APPLYING FOR THE HCP BUT WERE UNCERTAIN ABOUT THEIR OPTIONS AFTER THIS COVERAGE CONCLUDED.

Participants had fewer options if they were undocumented and therefore ineligible for government programs. Some of them, particularly those from the Cantonese non-enrollee group, had no interest in enrolling in the HCP. *"If I am ill, it would be less expensive if I go to see doctor in the government hospital,"* said one.

*"I did not apply because I heard that with September 11 insurance, there is a long wait to schedule an appointment, about 1 to 2 months. And I did not have time to see a doctor during the day."*

But many other people, especially from the two Fujianese non-enrollee groups, wanted to apply for the program but requested aid in completing their applications. *"Yes, I would apply for September 11 health insurance and it is good for us,"* said one. *"When we are sick, we can go to see a doctor, especially doctors in a big hospital. It's not good if the sickness drags on."*

SOME PARTICIPANTS KNEW THAT THEY HAD NO CHOICE IN HEALTH INSURANCE, BUT THE STATE OF THEIR HEALTH INFLUENCED THEIR DECISION TO SEEK COVERAGE AFTER THE PROGRAM ENDED.

Many people, particularly the Fujianese, knew that the ORP was their only option for health insurance. *"I have no choices but this September 11 insurance. I am lucky to have this insurance,"* said one.

Individuals in good health were more likely to go without insurance at the end of the program. *"After this September 11 insurance, I will go without insurance and pay for private doctor. I hope I will not get sick,"* acknowledged one of them.

For individuals with chronic illnesses, finding coverage was important. *"I will apply for Medicaid if I remain low-income or I will continue to use Gouverneur Hospital. I have a long-term chronic illness and it will be very expensive if I pay by myself."*

Participants had a growing awareness of health insurance. But for many, financial barriers and ineligibility prevented them from getting coverage in the future.

In summary, the program gave enrollees an increased understanding of health insurance and the U.S. health care system. Still, some enrollees continued to delay seeking treatment until they needed immediate medical care.

Some participants were also mistaken about their eligibility for government programs. Many thought that because they were eligible for this privately sponsored program they qualified for public health insurance programs.

#### **IV. LESSONS FOR SERVING AN IMMIGRANT COMMUNITY**

Service providers responded favorably to the HCP. Many of their insights and their suggestions for improvements echo the feedback provided by focus group participants.

##### **UNDERSTANDING THE ENTIRE TARGETED COMMUNITY**

###### **1. A better understanding of the Chinatown community at the outset of the program would have enabled providers to identify and address differences within the community, as well as to address commonly-held beliefs and fears that created programmatic challenges for service providers.**

Two characteristics of the Chinatown community challenge the design of the HCP.

The first was the diversity of the population. Subgroups within the community were overlooked, which resulted in poor outreach to these segments. Says one provider: *“What was on a lot of people’s minds: differences within the Chinese community . . . . More resources need to be poured into targeting underserved groups. But first, we need to define these groups.”*

*“The coverage lasts only a year. I hope it lasts longer...they should continue the program because so many people are out of jobs right now. No jobs and slow work affects everyone.”*

The second challenge was the level of fear that people had about sharing personal information. Many clients were hesitant to provide their phone numbers and other contact information to service providers because of their immigrant status, especially if they already had provided that information to Safe Horizon. With no formal structure for sharing confidential information, providers found their outreach efforts hindered: *“Some thought should be given to how clients can be contacted. A lot of these clients are not at home or don’t have phones. It’s haphazard to leave messages.”*

###### **2. Confusion and fear complicate serving immigrant communities.**

Many clients were not familiar with the American health insurance system. Two factors—confusion about issues related to health insurance and fears about immigration

status—made it more difficult for immigrants to understand the HCP and its two-pronged enrollment process.

Some service providers recommended that the ORP provide more thorough education to the enrollees through the use of written material about the HCP and the four service providers. In this way, clients could read the material after leaving the Safe Horizon information session. One service provider said that this extra effort to educate potential clients was important because so many of them did not understand the U.S. health care system: *“Because of the tradition of Chinese customers, not many understand the foundation of the program. Many worry about losing eligibility for Medicaid and FHP.”*

*“Because of the tradition of Chinese customers, not many understand the foundation of the program. Many worry about losing eligibility for Medicaid and FHP.”*

Trust was particularly an issue for undocumented individuals who were fearful about their immigration status. Consequently, some participants had difficulty believing in such programs as the ORP unless they heard about it from a reliable source.

*“...I am afraid it is a fraud, especially for people who are undocumented. If this is fake news, they think it will affect their asylum or even be arrested.”*

*“I feel the most reliable source is from the church,”* said one participant. *“If not, I am afraid it is a fraud, especially for people who are undocumented. If this is fake news, they think it will affect their asylum, or even be arrested.”* Another added that people are wary of such programs: *“If you haven’t got the card yet, they won’t believe it.”*

The difficulty in reaching the non-enrollees, two-thirds of them Fujianese, developed in part because they were less connected to the community. As well, this group had fewer community resources. Non-enrollees spoke limited English and were more likely to rely on word-of-mouth for information than on newspapers or radio.

The recent influx of Fujianese immigrants has delivered many new arrivals within the last ten years who still are paying off debts from their overseas journey. Consequently, the Fujianese willingly handle demanding work schedules, giving them less time to become involved in the community.

*“We don’t get news that fast. Fuzhounese people just keep their heads down and work.”*

## OVERCOMING FEARS AND INFORMATION GAPS

### 3. A program that serves a population with minimal understanding of the health insurance system must include an aggressive education campaign about health insurance.

Participants without prior exposure to health insurance were unlikely to make it a priority, and therefore did not place importance on getting additional information about the HCP.

*“It is only when someone is sick and needs a doctor that they get more information. When no one is sick, we don’t learn about these programs.”*

Although non-enrollees had heard of the program by word-of-mouth, that information often was erroneous. One woman recalled, *“I got the wrong message that I could not apply for DRM and the Safe Horizon card at the same time, or else I would be imprisoned.”*

Yet non-enrollees had no incentive to seek clarification of this information because many did not value the benefits of health insurance. Rampant misinformation became a barrier that prevented people from enrolling in the program.

### 4. Personal interaction helped overcome fears and gaps in information.

Many people enrolled because they were first able to meet the service providers. This inclusion of service providers at the information sessions was a major programmatic change that improved enrollment.

*“[CBOs] know who Safe Horizon is, and they feel comfortable referring clients. As a mainstream organization working with the Chinese community, we need to partner with the community.”*

All four service providers reported that their presence at Safe Horizon information sessions increased their enrollment numbers. It enabled them to make direct contact and to address any questions or concerns clients might have. *“Providers coming to the sessions have been effective in getting people to think about health insurance. Having people there is one less step for the participant. They don’t have to go home and make an extra phone call.”*

Service providers felt that their presence at the session provided the personal contact people needed to make them decide to enroll: *“What worked was having faces that participants would recognize from Union at the information sessions.”*

**5. A comprehensive approach should include cooperation with various organizations that target diverse segments of the community.**

The collaboration between Safe Horizon and the four service providers was challenging, but resulted in success. Confidentiality guidelines, however, restricted the amount of information that could flow among the agencies. One provider called confidentiality issues *“probably the weakest link.”*

Another provider indicated that information provided to HCP enrollees at the program’s inception was insufficient: *“In some cases, there were misinterpretations of who was offering what and how.”*

These problems were addressed in January 2003, when service providers started attending orientation sessions, a move that improved communication and collaboration.

Union strongly supported cooperative efforts with Safe Horizon, and attributes much of its enrollment success to this collaboration: *“Working together with the program [let] participants [know] this program is geared toward Union members and supported by Union.”*

Safe Horizon also said that collaboration with Chinatown agencies was important to the success of the program: *“As a mainstream organization working with the Chinese community, we need to partner with the community.”*

## **V. RECOMMENDATIONS FOR PROGRAM DESIGN AND POLICY**

**1. Complete a thorough needs assessment. This will improve access to health insurance by underserved groups in the community. It will also enable the community’s needs to be addressed in a culturally and linguistically appropriate manner.**

A program is effective only if it is based on a comprehensive awareness of the community it serves. In this case, focus groups highlighted two problems in program design. The first problem was the absence of outreach targeted at Fujianese. The second was the stringent documentation requirement.

This experience suggests that future programs should include funding for a comprehensive assessment of the health and social services needs of that specific community.

The HCP successfully enrolled many people in Chinatown's Cantonese community, but it did not initially plan to serve the sizeable Fujianese population. This subgroup's absence from formal data sources, including the Census 2000, meant that information about it had to be gathered from Fujianese community-based organizations.

As the cash-based nature of Chinatown's small businesses restricts the types of documentation that potential enrollees are able to obtain, many of them were frustrated by their attempts to gather the required documents. By accepting alternative documents, such as supporting documentation from co-workers, the HCP was able to successfully provide services to more people. The experience illustrated that confusion about eligibility and dissatisfaction about the program could have been minimized if this problem had been anticipated and accommodated early on.

Navigation of the health care system can be particularly challenging for uninsured people with limited English skills. Immigrants are more likely to access health care if program information and services are provided in their native language, and practitioners tailor services to the group's cultural background.

**2. Conduct comprehensive community health education campaigns. These efforts will build awareness of preventive health care and of the public and private insurance programs that are available.**

Community-based organizations are often the first source of health-related information and services for community residents. This study illustrates successful methods that increase access to health care. These include workshops about the benefits of health maintenance and health insurance, and training frontline staff so that they can better educate this population. Staff should be well versed on the range of public and private insurance options within and outside of this specific program, as well as on community-based health services.

Many immigrants exercised a "crisis mode" use of health care services. This behavior was caused by a lack of insurance, money and education about health maintenance. To counter this trend and promote preventative health care, successful methods include public service announcements, workshops and long-term community education efforts. Empowering community members makes them better equipped to learn about eligibility requirements and acquire health insurance.

The Chinese media was useful in raising general awareness about the ORP. But it was not often successful in conveying complete information about the program. Instead, eligible participants often developed their own interpretations of the ORP health program.

The most successful outreach supplements media outreach with individual contact through workers at local community-based organizations. Initial outreach to the Fujianese population was difficult because of their linguistic and social isolation from the Chinatown community. But once members of this sub-community began to learn about the ORP, news spread quickly.

**3. Provide automatic enrollment, personal attention, and education on how to choose a provider.**

The September 11th Fund served a community that needed both health insurance and job training. Packaging the two programs together enabled the Fund to make a greater number of individuals aware of its various services than if it had been stand-alone health insurance.

However, the need to be proactive in enrolling in the program was a program design feature that baffled many immigrants. With little formal education, limited English proficiency and a lack of familiarity with the U.S. health care system, many enrollees were inadequately prepared to choose a health provider.

**4. Provide continuing coverage for enrollees who have no alternative insurance when the ORP HCP concludes.**

The goal of ORP HCP was to provide short-term health coverage for people who were affected by the terrorist attacks of September 11 and at risk for increased health problems. As stipulated in the program, the HCP covers individuals who would not be eligible for other forms of health insurance, including government-sponsored programs such as Family Health Plus. Many individuals would become uninsured when the program ended.

Local and state governments should investigate ways to continue to insure this working population. The ORP HCP exposed a large number of participants to the benefits of preventive care. A study by the Kaiser Family Foundation, *The Costs of Not Covering the Uninsured*, found that the ability to access preventive care would result in increased productivity and a rise in the overall quality of health, two factors that benefit the individual and their employers as well.

**5. Expand health coverage accessibility by streamlining enrollment into other health insurance programs.**

DRM and the HCP ORP are two programs with successful streamlined enrollment processes. In both, easy enrollment expanded the number of insured individuals who otherwise would have limited access to health insurance.

States should be given the option to expand accessibility to health insurance programs by streamlining enrollment in Medicaid and Child Health Plus. Many public assistance programs have similar eligibility requirements. Relaxing documentation requirements and integrating information from these various program databases can simplify the application process. The result is that more people could access these programs.

**6. Encourage joint employer- and union-sponsored health insurance for the workers in Chinatown and other immigrant communities.**

Programs should be established to encourage employers to provide health insurance for their employees. One suggestion is to provide tax breaks for companies with fewer than 25 full-time employees, or to provide lower premiums. Union Health Center/UNITE, for example, illustrates how health benefits are an incentive for individuals to remain loyal and return to work in unionized garment factories. Other major business sectors in the Chinatown community, such as the restaurant, retail and service industries, should be encouraged to follow the unionized garment industry's lead in providing employer-sponsored insurance.



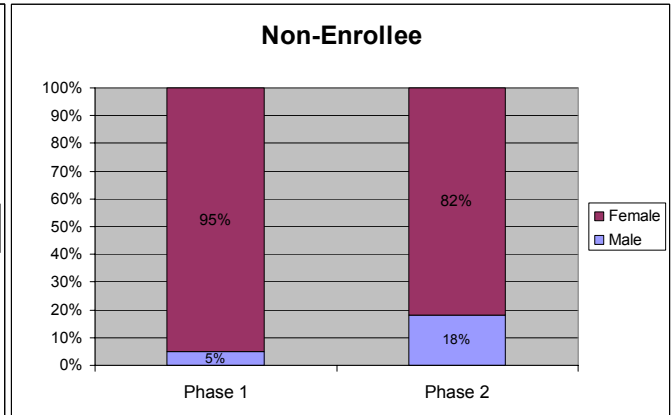
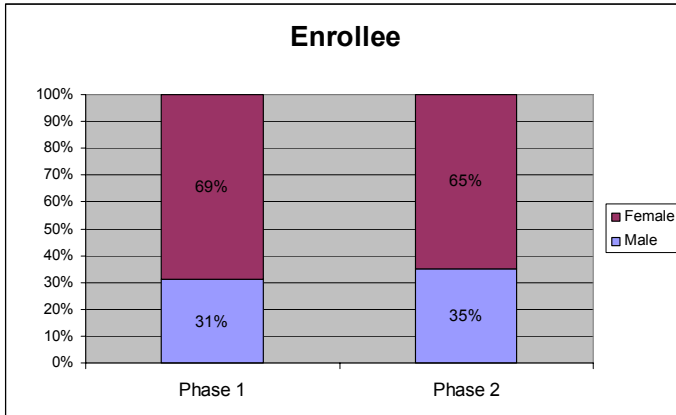
## APPENDIX A. DEMOGRAPHICS

### Study Participant Profile

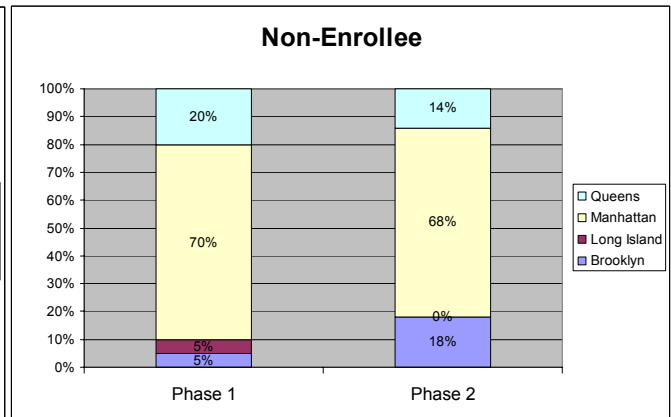
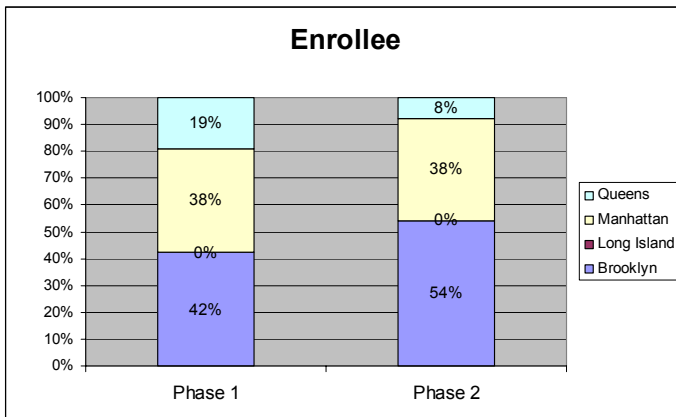
	E	NE	All		E	NE	All
<b>Total Participants</b>	52	42	94				
<b>Gender</b>				<b>Place of Birth</b>			
Male	33%	12%	23%	China—Canton	60%	33%	48%
Female	67%	88%	77%	China—Fujian	12%	64%	35%
				China—Hong Kong	17%	2%	11%
<b>New York Residence</b>				China—Zhe Jing	2%	0%	1%
Brooklyn	48%	10%	31%	Singapore	2%	0%	1%
Long Island	0%	2%	1%	South Korea—Seoul	2%	0%	1%
Manhattan	38%	69%	52%	Taiwan	2%	0%	1%
Queens	13%	19%	16%	United States	2%	0%	1%
				Vietnam—Saigon	2%	0%	1%
<b>Age</b>				<b>Immigration Status</b>			
20–29	2%	17%	9%	U.S. Citizen	46%	26%	37%
30–39	23%	21%	22%	Legal Resident	46%	43%	45%
40–49	40%	31%	36%	Other	8%	31%	18%
50–59	31%	26%	29%				
60+	4%	5%	4%	<b>Years in the U.S.</b>			
<b>Marital Status</b>				0–9	35%	60%	46%
Single	12%	12%	12%	10–19	38%	19%	30%
Married	88%	83%	86%	20–29	21%	17%	19%
Widowed	0%	2%	1%	30+	6%	2%	4%
Separated/Divorced	0%	2%	1%	N/A	0%	2%	1%
<b>Children</b>				<b>Primary Language</b>			
0	25%	14%	20%	Cantonese	79%	38%	61%
1	31%	17%	24%	English	4%	0%	2%
2	23%	38%	30%	Fuzhonese	2%	57%	27%
3	19%	19%	19%	Mandarin	15%	5%	11%
4	2%	5%	3%				
5	0%	7%	3%	<b>Command of English</b>			
<b>Highest Level of Education</b>				Very Well	8%	0%	4%
College+	17%	2%	11%	Well	13%	0%	7%
High School	40%	24%	33%	Not Well	46%	40%	44%
Grade School	38%	60%	48%	Not at All	33%	60%	45%
None	4%	14%	9%				

Note: E = Enrollees; NE = Non-Enrollees.

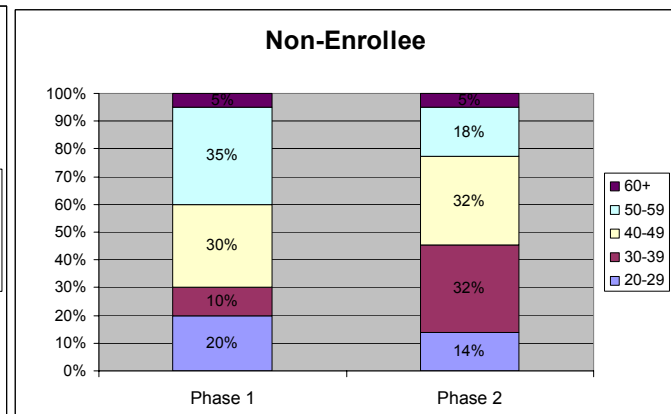
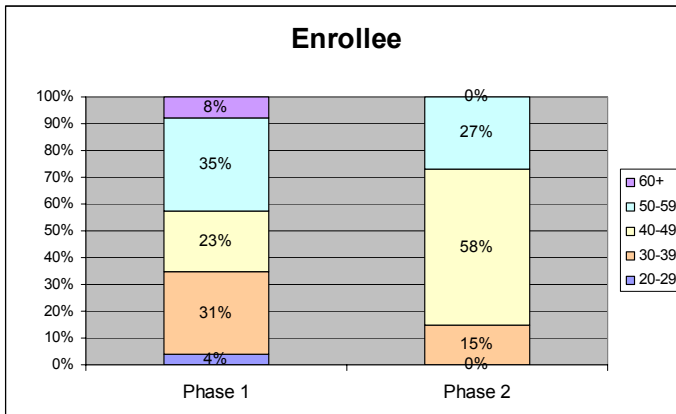
## 1. Gender<sup>14</sup>



## 2. Residence in New York

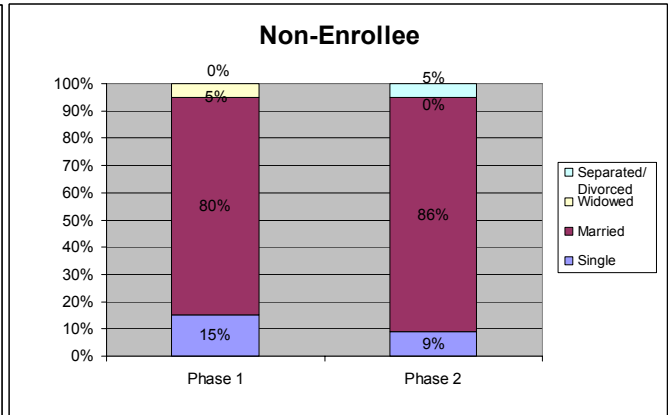
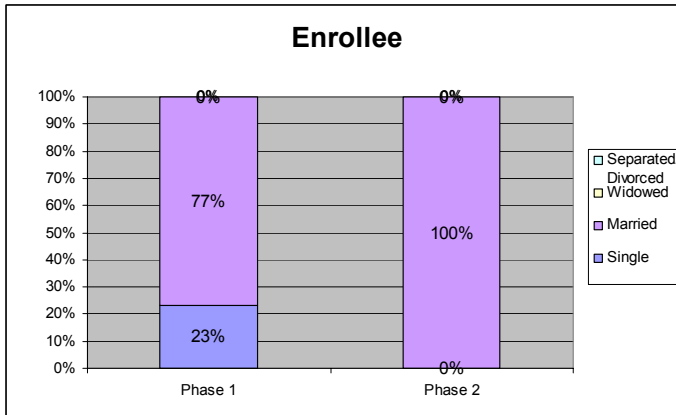


## 3. Age

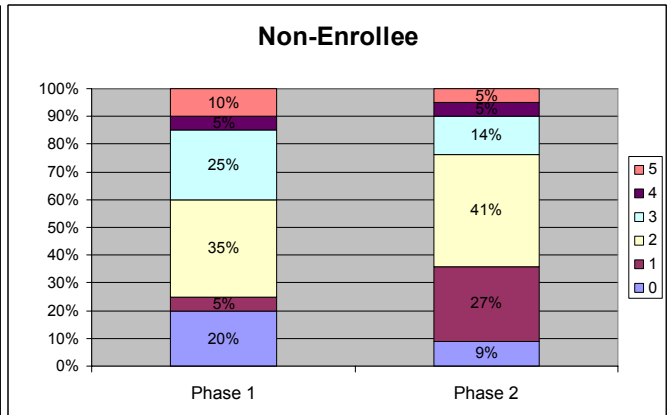
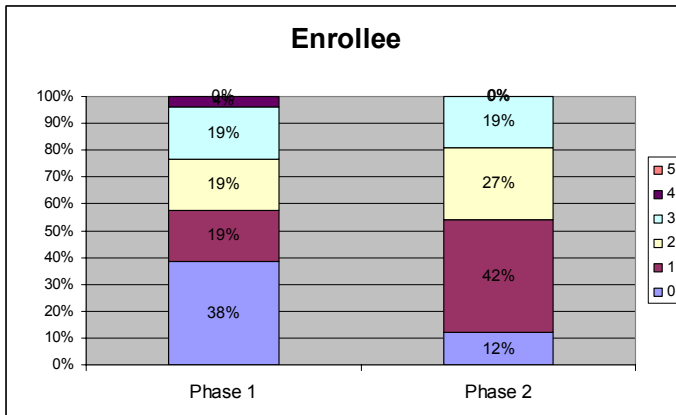


<sup>14</sup> The findings of the study reflect consolidation of Phase 1 (March 19, 2003 to April 11, 2003) and Phase 2 (July 9, 2003 to July 25, 2003).

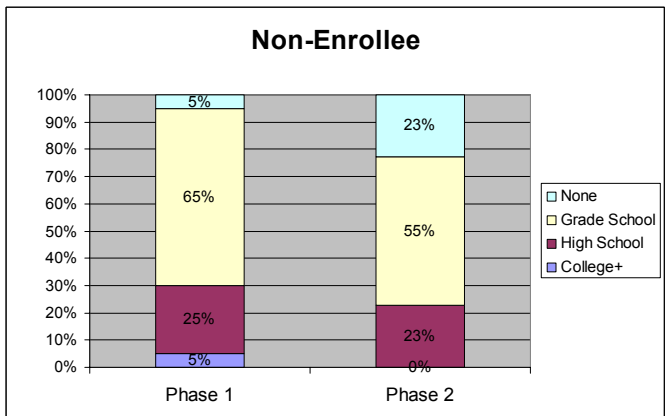
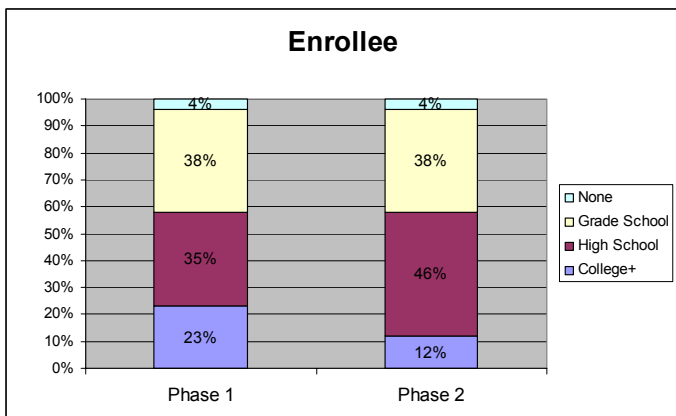
#### 4. Marital Status



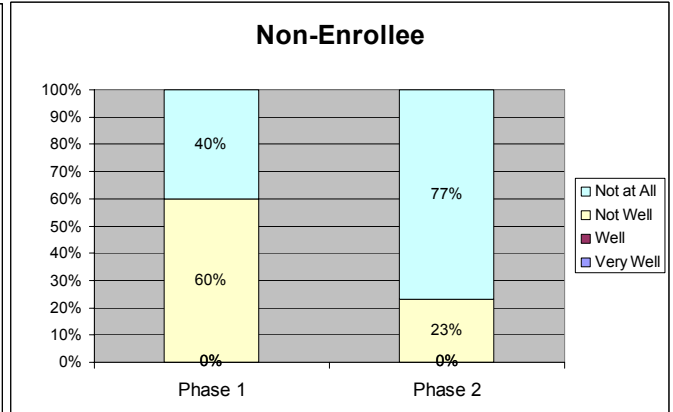
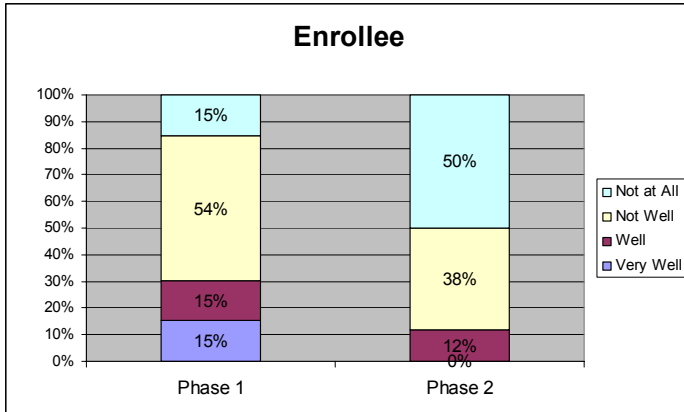
#### 5. Number of Children



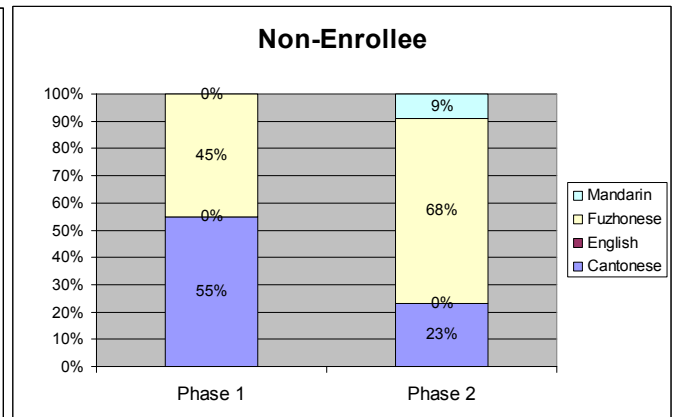
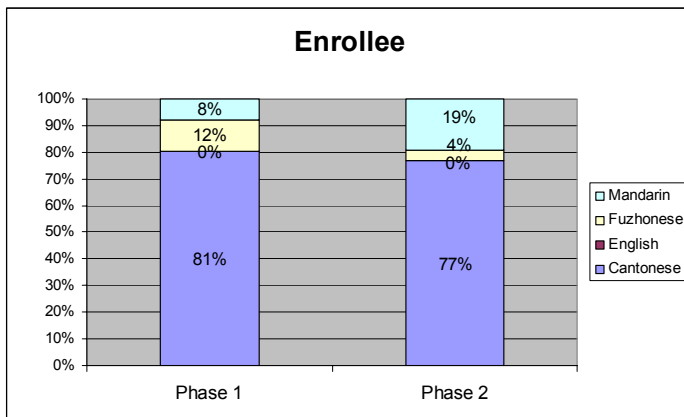
#### 6. Educational Attainment



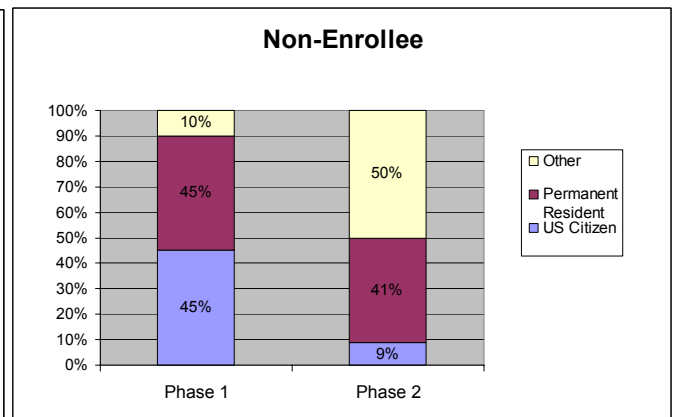
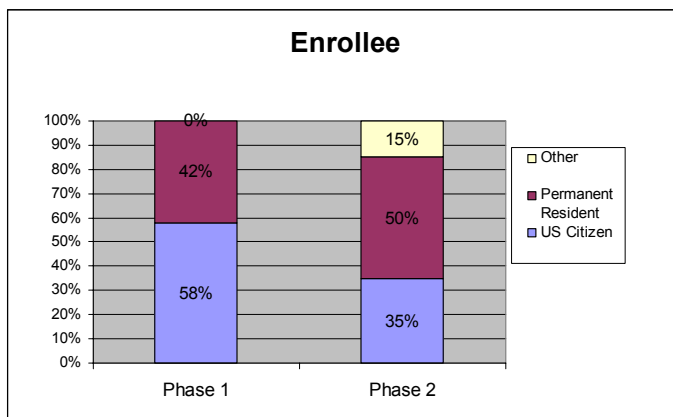
## 7. Command of English



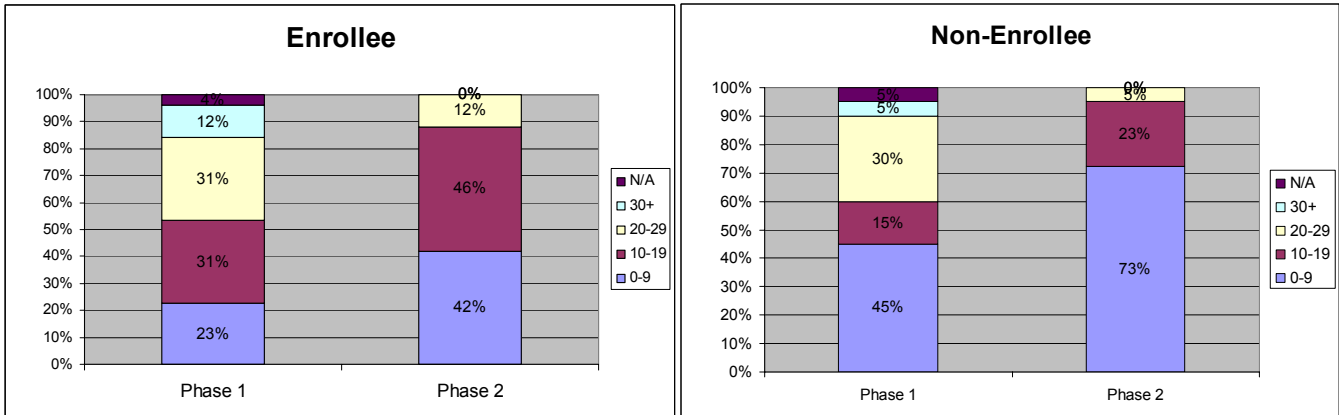
## 8. Primary Language



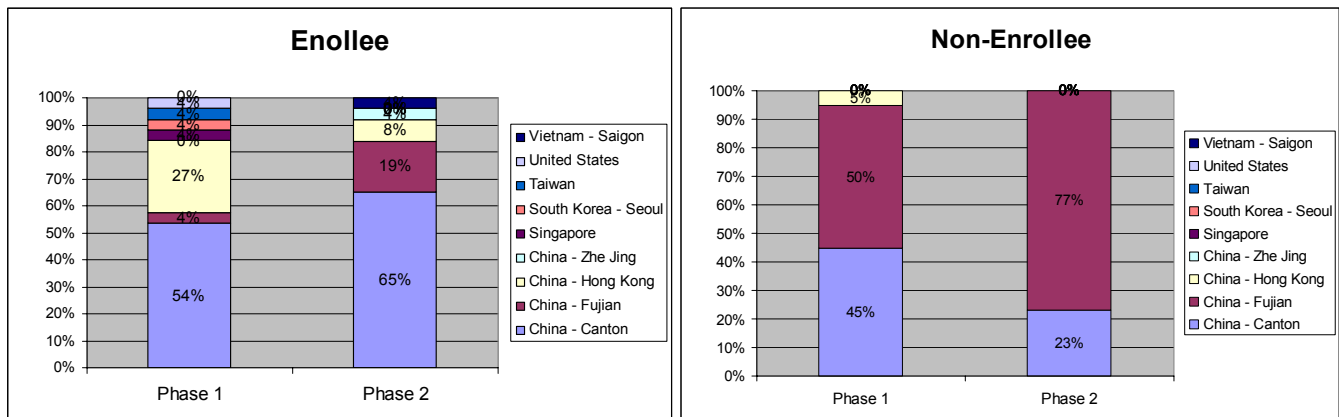
## 9. Immigration Status



## 10. Years in the United States



## 11. Place of Birth



## APPENDIX B. METHODOLOGY

The Asian American Federation staff conducted twelve focus group sessions, with an average size of eight individuals per group, in two phases (March 19 to April 11, 2003 and July 9 to July 25, 2003). Using cash incentives of \$35.00, a total of 98 NYC adults, predominantly of Chinese ethnicity, were recruited for the sessions. Both qualitative and quantitative measures were used in the form of focus groups and surveys. Participants were asked about their prior experiences with health insurance and health care, their knowledge of the program, enrollment experiences at Safe Horizon and at health service sites, their reasons for enrolling or not enrolling in the coverage plan, and their future plans for health coverage.

### **Recruitment of Participants**

#### *Enrollee Groups*

This study consisted of two Charles B. Wang sessions, two Union sessions, one Sunset session, and a combined Sunset/Affinity session. There were four participating providers and three focus groups per phase. Participants were chosen based on enrollment numbers at each provider site. In-person contacts were made with directors from the participating four provider sites to solicit support in recruiting participants. Guidelines, flyers and consent forms were subsequently provided to staff liaisons for recruiting purposes. Recruitment occurred entirely through the provider liaison because of patient confidentiality issues at provider sites. Sixty-three individuals agreed to participate, and 52 were interviewed during the focus group.

#### *Non-Enrollee Groups*

**Phase 1:** Various strategies (face-to-face encounters, email, and letters) were used to solicit the support of various Chinatown service agencies that provided vocational training, ESL classes, case management and social service assistance. Federation staff members attended various vocational programs and gave a brief presentation in Cantonese and Mandarin about the focus of the study and the criteria for participating in it. One of the non-participant focus groups was recruited and screened entirely by a service agency that works with the Fujianese population. Participants were recruited from the following organizations:

- Chinatown Manpower Project
- Chinese Christian Herald Crusades
- Chinese-American Planning Council

- Indochina Sino-American Community Center
- New Life Center

AAFNY staff conducted preliminary screening of interested individuals at service organizations, and conducted additional telephone screenings with potential non-participants. Individuals were reminded about the sessions by telephone. Thirty agreed to participate, but only 24 participated in the sessions. Of the 24, only 20 were actually eligible.<sup>15</sup>

**Phase 2:** The second phase of recruitment proved to be more challenging. It was difficult to find uninsured people, and the researchers concluded they had to reach people who were the least likely to know about The September 11<sup>th</sup> Fund or its health program. The following methods were used:

- Tables at health fairs and at a local park
- Press releases and interviews to Chinese language newspapers, radio stations, and television programs
- Posting of English and Chinese flyers in:
  - Jewelry stores along Canal Street
  - Restaurants located in Chinatown
  - Elementary schools
  - Grocery stores located on Pike Street and Hester Street
- Working with pastors in local churches to hand out English and Chinese language flyers to their congregation<sup>16</sup>
- Safe Horizon staff sent English and Chinese language flyers to attendees of their most recent sessions
- Contacting previous non-participants to inquire if they knew of anyone who would be interested in participating.

---

<sup>15</sup> Though screened twice, four participants were considered ineligible during the focus group session.

<sup>16</sup> Church of Grace Fujianese, Chinese United Methodist Church, Church of the Transfiguration, Chinese Evangel Mission Church, and Grace Faith Church.

The community-based organizations used were:

- Chinese-American Planning Council
- Chinatown Resource Center
- Lower Eastside Service Center
- New Life Center

Ultimately, the most effective method of outreach was to employ a Fujianese outreach specialist to work with the New Life Center, a social service agency that serves a large number of uninsured individuals.

AAFNY staff conducted preliminary screenings at service organizations with interested individuals, and conducted additional telephone screenings with potential non-participants. People were reminded about the sessions by telephone. Twenty-five individuals registered but only 22 participated.

The most successful outreach resulted from partnering with community-based organizations. By appearing in person with the support of a trusted service agency, AAFNY recruiters made people more willing to be questioned to determine their eligibility for the study. Contrary to expectations, newspaper articles, radio announcements, and mailings were unsuccessful and elicited few responses and few participants. This lack of success, however, may have been influenced by the Federation's computerized telephone system. It may have been difficult for people unfamiliar with an automated telephone system or limited English skills to navigate to the correct extension.

### **Procedure**

Focus groups were held either at the service site or off-site in the Chinatown community. Participants were first required to sign consent forms. Each session lasted for ninety minutes, with an additional thirty minutes reserved for surveys. A trilingual facilitator conducted nine focus groups primarily in Cantonese, but also in Mandarin and English. Two Fuzhounese-speaking facilitators conducted the remaining three focus groups in both Fuzhounese and Mandarin. All 12 focus groups were conducted in the following manner:

- The facilitator began with a short introduction about the purpose of the session and explained the procedure for answering questions.



- Participants' concerns about the focus group session were addressed. One common concern was a fear about sharing the recordings with third parties; another was that the AAFNY staff was involved in the administration of the ORP HCP.
- The facilitators and AAFNY staff undertook on-site note taking.
- Sessions were audio-taped using two recorders.
- Surveys were completed following the focus group sessions with the aid of the facilitators and AAFNY staff.
- Participants were provided \$35.00 in cash at the conclusion of the sessions.

To ensure accuracy, facilitators also transcribed the sessions verbatim based on the recordings.

## **Focus Group Process**

### *Structure*

Facilitators established rules for the group. These included a speaking protocol, showing respect for differences of opinions and honoring the confidentiality of information shared in the group. Each participant was invited to answer open-ended questions posed by the group moderator in turn, and some participants were asked to elaborate on issues that seemed significant.

### *Focus Group Session Protocol*

The focus group sessions focused on information that would give an understanding of the participants' experiences in accessing health care. This information fell into six categories:

- prior experiences with health insurance and health care
- knowledge of the program
- enrollment experiences at Safe Horizon and at health service sites
- reasons for enrolling or not enrolling in the coverage plan
- participants' future plans for health coverage

### *Demographic Survey*

This form was used to obtain data by about the following: gender, birthplace, age, ethnic background, immigration status, marital status, educational level, occupation, primary language, health needs, health use, familiarity with health insurance programs, and how the participants first heard about the ORP.

### *Group Dynamics*

Except in a few cases, participants had no prior contact with each other. It appeared that they were uncomfortable at the beginning but warmed up considerably by the second or third question. Female participants tended to be more open about their health experiences while male participants tended to be more negative about their health experiences, or to talk very briefly about them. All were fairly open to the idea of discussing their health coverage experience and were willing to elaborate upon personal experiences.

### *Data Analysis*

Two AAFNY staff members analyzed each transcript independently to ensure reliability. This process was repeated for each focus group session and involved coding semantic units into the topic categories. There was then a second round of coding and analysis; this time groups were consolidated according to enrollment status and phase. This second step enabled AAFNY staff to extract themes.

## APPENDIX C. SERVICE PROVIDERS

### **Affinity Health Plan's Sunrise Program**

Affinity is an independent, not-for-profit managed care company dedicated to serving the needs of low-income populations. Affinity provides primary and specialty care through 1,300 primary care clinicians and 5,000 physician specialists working in a variety of practice sites, including Federally-Qualified Health Centers (FQHCs), non-FQHC community health centers, private group and office practices, and hospital-based practices. Affinity also operates in more than 60 hospitals (including academic medical centers, community hospitals and municipal facilities).

### **Chinatown Health Partnership at Charles B. Wang Community Health Center**

CBWCHC is a non-profit, community based health care facility committed to serving Asian Americans in New York City. As part of the Chinatown Health Partnership with Lutheran Family Health Centers, CBWCHC has been providing comprehensive, low-cost health services to the Chinese speaking community since 1971. Preventive, primary care and specialty care services are provided in three convenient locations (two in Chinatown and one in Queens). All services have no monthly fee and a low \$2 co-pay per outpatient visit and a \$5 co-pay per prescription per monthly supply.

### **Chinatown Health Partnership at Lutheran Family Health Center, Sunset Park**

Sunset is the healthcare safety net provider for underserved communities throughout Southwest Brooklyn. As part of the Chinatown Health Partnership with CBWCHC, this multi-site network provides preventive, primary care and specialty services to ethnically diverse neighborhoods. There are nine community health centers in the network. Staff are bilingual and bicultural and are cross-trained to provide efficient and culturally competent services. Sunset Park offers family-oriented comprehensive health, dental and behavioral care, as well as a full range of specialty and support services including HIV Counseling/Testing.

### **Union Health Center**

Union is a primary care and multi-specialty ambulatory health center providing healthcare to the active and retired members of the Union of Needletrades, Industrial, and Textile Employees (UNITE) as well as their families. Founded in 1914, the center has 12 bilingual and culturally competent staff members to care for patients in Chinese or Spanish. The center provides preventive and specialty services, such as mammography and physical therapy, to union members and their family.

## Health Provider Program Participant Profile<sup>17</sup>

	Totals	Affinity	Charles B. Wang	Sunset	Union
<b>Total Enrollment</b>	11,364	2811	1201	451	6901
Primary Beneficiaries	6031	2224	676	311	2820
<b>Primary Language</b>					
English	21.9%	53.6%	7.5%	25.7%	0.9%
Cantonese	37.5%	7.7%	52.5%	18.2%	71.6%
Chinese	12.1%	1.9%	20.1%	3.8%	22.8%
Mandarin	4.6%	2.1%	9.8%	4.3%	2.3%
Fuzhounese	1.8%	0.6%	4.8%	1.9%	0.1%
Spanish	9.6%	17.7%	0.9%	19.6%	0.0%
<b>Age Categories</b>					
Under 20 years	0.2%	0.2%	0.1%	0.3%	0.1%
21–30	10.1%	16.1%	4.7%	19.4%	0.1%
31–40	23.0%	29.6%	23.8%	27.4%	11.0%
41–50	31.8%	31.3%	31.9%	30.9%	32.9%
51–60	27.7%	18.7%	30.8%	17.5%	43.7%
61+	7.4%	4.1%	8.7%	4.6%	12.2%
<b>Gender Composition</b>					
Male	34.8%	54.1%	22.3%	56.0%	6.7%
Female	61.0%	41.1%	72.1%	41.8%	88.9%

<sup>17</sup> These totals are based on enrollment numbers as of August 31, 2003.

### Overview of Health Provider Services

	<b>Affinity</b>	<b>Charles B. Wang</b>	<b>Sunset</b>	<b>Union</b>
<b>Boroughs Served</b>	Bronx, Brooklyn, Manhattan, Queens, Richmond	Manhattan	Brooklyn	Manhattan
<b>Program Structure &amp; Administration</b>	PHSP	Direct Access Health Center	Direct Access Health Center	Direct Access Health Center
<b>Target Population &amp; Enrollment</b>	Medicaid beneficiaries, and other low-income uninsured persons	Asian Americans in New York	Underserved communities throughout Southwest Brooklyn	Active and retired members of the UNITE union and their families
<b>Scope of Services</b>	Comprehensive benefit package including inpatient, emergency room, primary and specialty physician, pharmacy, dental, behavioral health, laboratory, radiology, home health and related services.	Preventive, primary and specialty care	Preventive, primary & specialty care, dentistry, behavioral health care	Preventive, primary and specialty services
<b>Languages</b>	English, Spanish, Chinese, Russian, French(Creole)	Cantonese, Mandarin, Toisanese, Shanghainese, Taiwanese	Cantonese, Mandarin, Spanish, Arabic, Hebrew, Haitian Creole	Cantonese, Mandarin, Spanish, French Creole, Russian, Tagalog, Vietnamese
<b>Years Serving the Community</b>	18	30	120	89
# employees	648		~4000	
Full-Time	646	20+	20+	20+
Part-Time	2	20+	20+	20+
Primary Care	Y		Y	Y
OB/GYN	Y	Y	Y	Y
Dental	Y	Y	Y	
Vision	Y	Y		Y
Acupuncture	Y (Rehab only)		Y	
Prescription Drugs	Y	Y	Y	Y
Lab/X-Ray	Y	Y	Y	Y
Mental Health	Y	Y	Y	Y
Hospital Coverage	Y			Y
Specialty Care	Y	Y	Y	Y
Social Service		Y	Y	Y
Transportation	Y (Ambulance)	Y		Y
Other	Chiropractic, Emergency Room, Family Planning, PT and OT, Podiatry, DME and Prosthetics, Speech and Hearing Services		MRI/CAT Scan	Mammography, Bone Density, Radiology

## APPENDIX D. REFERENCES

- Dhooper, SS. (2003). "Health Care Needs of Foreign-Born Asian Americans: An Overview," *Health and Social Work* 28 (1): 63–73.
- Ku, L., and T. Waidmann. (2003). *How Race/Ethnicity, Immigration Status and Language Affect Health Insurance Coverage, Access to Care and Quality of Care Among the Low-Income Population*. The Henry J. Kaiser Family Foundation.
- Lee, D. (1999, July 4). "When Insurance Is A Tough Sale," *The Los Angeles Times*.
- Ma, GX. (1999). "Between Two Worlds: The Use of Traditional and Western Health Services by Chinese Immigrants," *Journal of Community Health* 24 (6): 421–37.
- Sengupta, S. (1999, March 14). "Far From Home, Alone – A Special Report; Young Immigrants Find a Hard New Land," *The New York Times*.
- U.S. Census Bureau (2003). *Health Insurance Coverage in the United States: 2002*.

## ACKNOWLEDGMENTS

Funding support for this study has been generously provided by The Commonwealth Fund.

The Federation acknowledges the support of the following organizations, without which this study would not have been possible:

### **Health Care Providers**

Affinity Health Plan  
Charles B. Wang Community Health Center  
Chinatown Health Partnership at Lutheran Family Health Centers, Sunset Park Brooklyn  
Union Health Center

### **Recruitment Assistance**

AM 1480  
Asian and Pacific Islander Coalition on HIV/AIDS, Inc.  
China Press  
Chinatown Manpower Project  
Chinatown Senior Center  
Chinatown YMCA  
Chinese Christian Herald Crusades  
Chinese Evangel Mission Church  
Chinese United Methodist Church  
Chinese-American Planning Council  
Church of Grace Fujianese  
Church of the Transfiguration

**Recruitment Assistance (cont.)**

Grace Faith Church  
Hamilton–Madison House Chinatown Resource Center  
Indochina Sino–American Community Center  
Lower Eastside Service Center  
Lutheran Family and Community Services New Life Center  
P.S. 1  
P.S. 2  
P.S. 124  
P.S. 126  
P.S. 130  
M.S. 131  
Ming Pao Daily News  
Safe Horizon  
Sing Tao Jih Pao  
Sinovision Television  
St. Vincent’s Hospital, Department of Community Medicine—Chinatown Clinic  
The September 11th Fund  
University Settlement  
World Journal

The Asian American Federation of New York is also grateful to the following individuals who have offered invaluable advice, insights, information, and assistance on the study:

Melissa Aase	University Settlement
Aleli Alvarez	Asian and Pacific Islander Coalition on HIV/AIDS, Inc.
Julia Chan	Hamilton–Madison House, Chinatown Resource Center
Kennis Chan	Hamilton–Madison House
Manna Chan	Lower Eastside Service Center
Xiu Dan Chan	Consultant
Aina Chen	Chinatown Health Partnership at Lutheran Family Health Center, Sunset Park Brooklyn
Dr. Diana Chen	Gouverneur Hospital—Asian Bicultural Clinic
Jeffrey Chen	Chinese–American Planning Council
Peter Cheng	Indochina Sino–American Community Center
Chris Cho	Chinese Community Social Service and Health Council
Dr. Irene Chung	Hunter College School of Social Work
Jeanne Eng	Asian American Federation of New York
Kelly Eng	Safe Horizon
James Ho	Affinity Health Plan
Katy Ho	Consultant
Natalie Hom	Hamilton–Madison House, Chinatown Resource Center
Sabrina How	The Commonwealth Fund
Christina Hsu	Asian American Federation of New York
Yingsi Huang	Chinatown Manpower Project
Kymie Hwang	Sing Tao Jih Pao
Suzanne Immerman	The September 11th Fund

Parag Khandhar	Asian American Federation of New York
Nancy Khuu	Lutheran Family and Community Services New Life Center
Charlie Lai	Asian American Federation of New York
Ken Lam	Chinese Christian Herald Crusade
Maggie Lau	Asian American Federation of New York
Mike Lau	New York Police Department
Hong Shing Lee	Chinatown YMCA
Steven Lee	Affinity Health Plan
Ray Leung	Chinese-American Planning Council
Winnie Li	Asian American Federation of New York
Frank Liang	Union Health Center
So Lan Liang	Hamilton-Madison House Chinatown Resource Center
Lucas Lin	World Journal
Kit Lo	Charles B. Wang Community Health Center
Larry May	Chinatown Manpower Project
LouAnn Perez	Asian and Pacific Islander Coalition on HIV/AIDS, Inc.
Dr. David Sandman	Harris Interactive, Inc./formerly with The Commonwealth Fund
Cathy Schoen	The Commonwealth Fund
Vicki Shu	Asian American Federation of New York
William Stamadis	Affinity Health Plan
Kimberly Tait	United Services Group
Wendy Wang	Lutheran Family and Community Services New Life Center
Billy Wong	Chinatown YMCA
Lisa Wong	Chinatown YMCA
Vicki Wong	Chinese-American Planning Council
Jacqueline Woo	Asian American Federation of New York
Alex Wu	Asian American Federation of New York
Henry Ye	Lutheran Family and Community Services New Life Center
Steve Yip	Chinese-American Planning Council
Millie Zhou	Asian American Federation of New York



## RELATED PUBLICATIONS

In the list below, items that begin with a publication number can be found on The Commonwealth Fund's website at [www.cmwf.org](http://www.cmwf.org). Other items are available from the authors and/or publishers.

---

**#737** *New York's Disaster Relief Medicaid: What Happened When It Ended? A Focus Group Study* (July 2004). Eugene LeCouteur, Lake Snell Perry & Associates.

**#546** *Health Coverage for Immigrants in New York: An Update on Policy Developments and Next Steps* (July 2002). Deborah Bachrach and Karen Lipson, Kalkines, Arky, Zall & Bernstein LLP. This field report examines the way in which federal welfare reform restricted legal immigrants' access to Medicaid and how a New York State Court of Appeals' decision provides coverage for those previously denied.

**#507** *Lessons from a Small Business Health Insurance Demonstration Project* (February 2002). Stephen N. Rosenberg, PricewaterhouseCoopers LLP. This report finds that the recently concluded pilot project, the Small Business Health Insurance Demonstration, launched by New York City in 1997, was successful in providing a comprehensive, low-cost insurance option for firms with two to 50 workers. But poor implementation and marketing, plus flaws in product design, prevented the program from catching on among small businesses.

**#485** *Implementing New York's Family Health Plus Program: Lessons from Other States* (November 2001). Rima Cohen and Taida Wolfe, Greater New York Hospital Association. Gleaned from research into the ways 13 other states with public health insurance systems similar to New York's have addressed these matters, this report examines key design and implementation issues in the Family Health Plus (FHP) program and how Medicaid and the Child Health Plus program could affect or be affected by FHP.

**#484** *Healthy New York: Making Insurance More Affordable for Low-Income Workers* (November 2001). Katherine Swartz, Harvard School of Public Health. According to the author, Healthy New York—a new health insurance program for workers in small firms and low-income adults who lack access to group health coverage—has so far been able to offer premiums that are substantially less than those charged in the private individual insurance market.

**#458** *Expanding Access to Health Insurance Coverage for Low-Income Immigrants in New York State* (March 2001). Deborah Bachrach, Karen Lipson, and Anthony Tassi, Kalkines, Arky, Zall & Bernstein, LLP. This study of health insurance coverage among New York State's legal immigrants finds that nearly 170,000 low-income adults who would otherwise be eligible for public insurance programs are denied coverage solely because of their immigration status.

**#444** *Creating a Seamless Health Insurance System for New York's Children* (February 2001). Melinda Dutton, Kimberley Chin, and Cheryl Hunter-Grant, Children's Defense Fund–New York. New York has recently brought Medicaid and Child Health Plus together, making the two programs more compatible. This paper takes a comprehensive look at both these programs in order to identify areas of continued programmatic disparity and explore ways to bridge differences.

