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Covering New Americans: A Review of Federal and State Policies Related to Immigrants' Eligibility and Access to Publicly Funded Health Insurance

By Shawn Fremstad and Laura Cox
Center on Budget and Policy Priorities

November 2004

THE HENRY J. KAISER FAMILY FOUNDATION

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The Kaiser Commission on Medicaid and the Uninsured provides information and analysis on health care coverage and access for the low-income population, with a special focus on Medicaid's role and coverage of the uninsured. Begun in 1991 and based in the Kaiser Family Foundation's Washington, DC

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EXECUTIVE SUMMARY

Prior to the passage of the Personal Responsibility and Work Opportunity and Reconciliation Act of 1996—known as the 1996 welfare law—legal immigrants were eligible for Medicaid on the same basis as U.S. citizens if they met financial and other eligibility requirements. The welfare law imposed unprecedented restrictions on legal immigrants' eligibility for various public benefits, including Medicaid. These restrictions also applied to the State Children's Health Insurance Program (SCHIP), which was implemented in 1997.

Since the passage of the eligibility restrictions, the number of legal immigrants receiving Medicaid coverage has declined significantly and the gap in overall health insurance coverage between low-income U.S. citizens and immigrants has widened. In response to the restrictions, many states established programs—funded solely with state dollars—that provide the same or very similar health care coverage as Medicaid to some or all legal immigrants who were made ineligible by the restrictions. Some states have also undertaken efforts to encourage enrollment of immigrants who remain eligible for Medicaid and SCHIP and to improve access to care among immigrants.

This brief provides an overview of health coverage challenges facing immigrants, the federal rules regarding immigrants' eligibility for Medicaid and SCHIP, and state efforts to provide replacement coverage for immigrants who are ineligible for Medicaid and SCHIP. It also reviews actions states can take to encourage enrollment of eligible immigrants in public health coverage and to improve immigrants' access to care.

Immigrants and Health Care Coverage

Health coverage for immigrants remains a pressing policy challenge. Immigrants have high uninsured rates, and, as such, experience difficulties accessing necessary care:

- **Recent immigrants are much less likely to have health insurance than citizens.** In 2003, 52 percent of recent immigrants—noncitizens who have lived in the United States for six years or less—lacked insurance compared to 15 percent of native citizens.

- **Although most children living in low-income immigrant families are citizens, these children have higher uninsured rates than citizen children with native-born parents.** About 26 percent of low-income *citizen* children with *noncitizen parents* are uninsured, compared to 16 percent of such children with citizen parents.

- **The disparity in health coverage between immigrants and citizens has widened since enactment of the 1996 welfare law, and the number of low-income legal immigrants with health coverage has significantly declined.** This decline in coverage rates for low-income immigrants occurred despite an increase in the share of low-income immigrants with employer-based coverage. These increases were more than offset by sharp declines in Medicaid coverage among noncitizens. However, even though coverage among immigrants has declined, immigrants are not primarily responsible for the recent growth in the overall number of uninsured Americans.

- **Disparities in coverage are not explained by differences in work effort.** The vast majority of immigrants have a full-time worker in the family, but a disproportionate number of immigrants work in low-wage jobs that are less likely to offer health benefits.

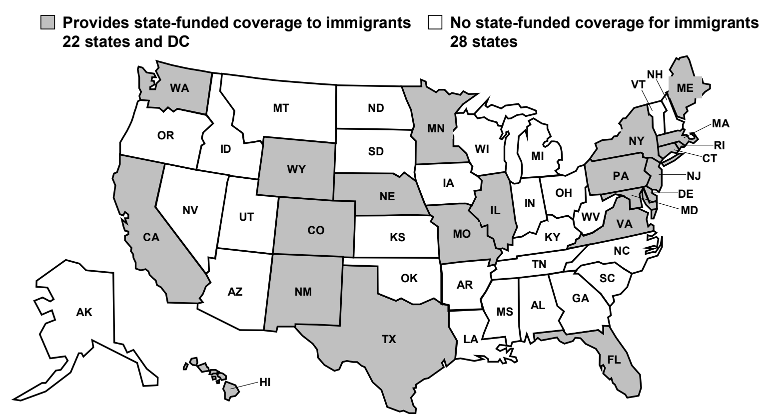
- **Immigrants without health insurance have less access to health care and are less likely to obtain needed care than immigrants with insurance.** Lack of insurance has important health consequences and contributes to disparities in access to care between immigrants and natives. Immigrants are less likely than other individuals to have a regular source of care, visit a doctor, or obtain preventive care.

State Coverage for Immigrants

A number of states have undertaken efforts to help address the coverage limitations imposed on immigrants by the 1996 welfare law. As of 2004, nearly half (23) of states used state funds to provide coverage to legal immigrants who are ineligible for Medicaid or SCHIP because of the 1996 restrictions (Figure 1). Some states also used these programs to extend coverage to undocumented immigrants—particularly children and pregnant women—who were ineligible for Medicaid prior to 1996. Additionally, seven states, including two states that do not provide any state-funded coverage for immigrants, used a recently available option to provide SCHIP-funded coverage for prenatal care regardless of the immigration status of the mother.

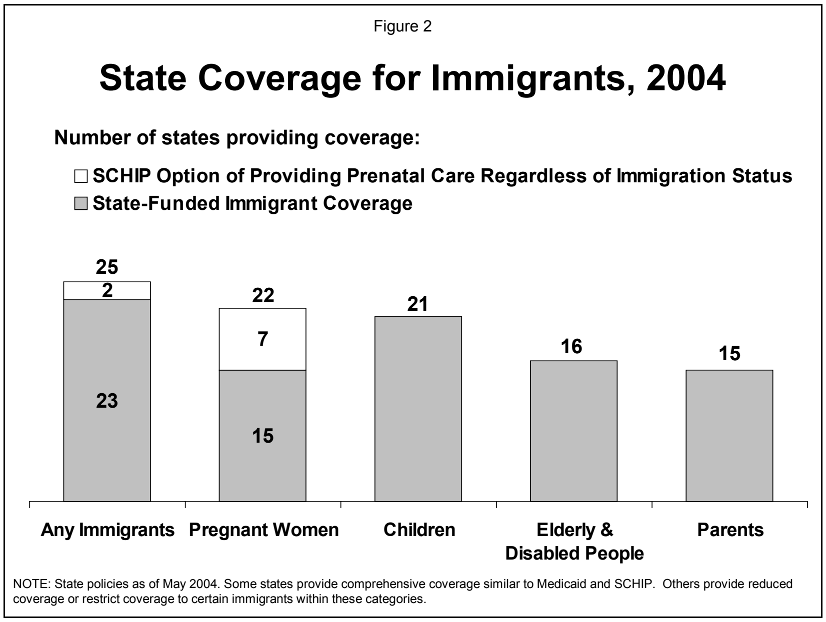
Figure 1

State-Funded Coverage for Immigrants Who are Ineligible for Medicaid or SCHIP, May 2004



NOTES: In some cases coverage is only available to limited categories of immigrants and/or is substantially more limited than Medicaid or SCHIP coverage. Arkansas, Illinois, Massachusetts, Michigan, Minnesota, Nebraska, and Rhode Island use federal SCHIP funds to provide prenatal care coverage regardless of immigration status.

Accordingly, in total, 25 states provided state-funded coverage and/or utilized the SCHIP option of providing prenatal care without regard to immigration status. States most commonly provided coverage to some or all immigrant children or pregnant women who are otherwise ineligible for Medicaid or SCHIP (Figure 2).



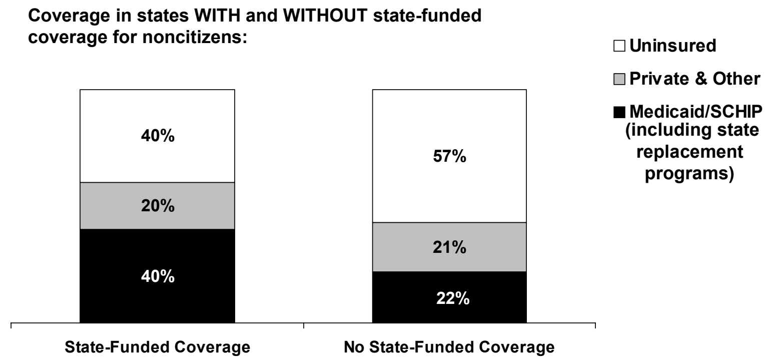
Most of the state-funded programs for immigrants had the same scope of coverage and rules as Medicaid (or SCHIP). However, some states only provided the coverage to very limited categories of immigrants. Further, a few provided health coverage that is significantly more limited than Medicaid or SCHIP or that has other rules that can limit participation, such as premiums, cost sharing, more burdensome enrollment procedures, and enrollment caps.

In addition to providing coverage to immigrants who are ineligible for Medicaid or SCHIP, states can help improve immigrant coverage rates by reducing enrollment barriers for those who remain eligible. To facilitate enrollment, some states have undertaken efforts to address immigrant confusion surrounding eligibility, to reduce language barriers, and to alleviate immigrant concerns around the impact of enrolling in coverage on immigration status. States also can help improve immigrant health by promoting access to care among immigrants. States can take several steps to increase immigrants' access to care, including assuring that health care providers provide appropriate assistance to individuals with limited English proficiency and educating immigrants about the availability of Emergency Medicaid.

It appears that state-funded coverage programs for immigrants and other state efforts have been effective in reducing uninsured rates among immigrants. Noncitizen children living in states with state-funded programs have lower uninsured rates than such children living in states without such programs (Figure 3). It seems likely that the difference is due not only to the presence of the state-funded programs but also to more successful outreach efforts.

Figure 3

Health Insurance Coverage Among Low-Income Noncitizen Children, 2002



Note: Low-income is less than 200% FPL. Analysis excludes states that have state-funded programs that are more limited than Medicaid, are subject to enrollment or funding caps, or provide coverage to limited types of legal immigrants who are ineligible for Medicaid. States excluded completely from the analysis of children's coverage are the District of Columbia, Florida, New Mexico, and Texas. Other coverage includes private coverage and other public coverage, including Medicare and Veterans' benefits.
Source: Center on Budget and Policy Priorities' analysis of Mach 2003 Current Population Survey Data.

In sum, the 1996 welfare law limits on Medicaid and SCHIP eligibility for immigrants had a significant impact, contributing to high uninsured rates among immigrants, widening the disparity in coverage rates between immigrants and native citizens, and increasing immigrant coverage disparities across states. A number of states have undertaken efforts to provide replacement coverage programs for immigrants who are ineligible for Medicaid and SCHIP and to encourage enrollment and access to care among immigrants. It appears these efforts have been successful in helping to stem the impact of the eligibility restrictions, but immigrants continue to face disproportionate challenges to accessing coverage and care.

I. INTRODUCTION

Over the past several years, the number of legal immigrants[1] receiving Medicaid or SCHIP coverage has declined significantly and the gap in overall health insurance coverage between low-income U.S. citizens and immigrants has widened. These trends are due in part to eligibility restrictions imposed on many legal immigrants by the Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA) of 1996, legislation commonly referred to as the 1996 welfare law.[2] The most significant restriction—known as the "five-year bar"—prohibits most legal immigrants from receiving Medicaid or SCHIP during their first five years residing in the United States. Also contributing to these trends are various barriers that have deterred participation in Medicaid or SCHIP by members of immigrant families who are not subject to the PRWORA restrictions and remain eligible for benefits.

A number of strategies to reduce these Medicaid and SCHIP eligibility and access barriers have emerged over the past few years. As of 2004, some 23 states provided solely state-funded health insurance coverage to some or all legal immigrants subject to the restrictions on federally-funded coverage. In addition, the federal government has adopted new policies and clarified existing ones that, if implemented by states and local agencies, could improve access to coverage for members of immigrant families who remain eligible for Medicaid and SCHIP or are eligible for state-funded coverage. Finally, the Congress is considering bipartisan proposals to lift some of the immigrant eligibility restrictions in Medicaid and SCHIP.

This report reviews these state and federal efforts. The report begins with a summary of recent research examining trends in health insurance coverage among immigrants and the impact lack of coverage has on immigrants' access to and use of health care. It then describes the federal rules related to immigrants' eligibility for Medicaid and SCHIP. Finally, it provides an overview of state programs designed to replace Medicaid and SCHIP benefits for legal immigrants and of state efforts to reduce barriers faced by immigrants in accessing health coverage and care.

II. BACKGROUND

A. Immigrants and Health Insurance Coverage

Immigrants are much less likely to have public or private health insurance than native citizens. Given their low rates of coverage, it is not surprising that immigrants constitute a significant share of the uninsured in the United States. Of the 44.7 million people without health insurance in 2003, about 9.4 million—21 percent — were noncitizens.[3] Children living in immigrant families constitute an even larger share of all uninsured children. About one-third of

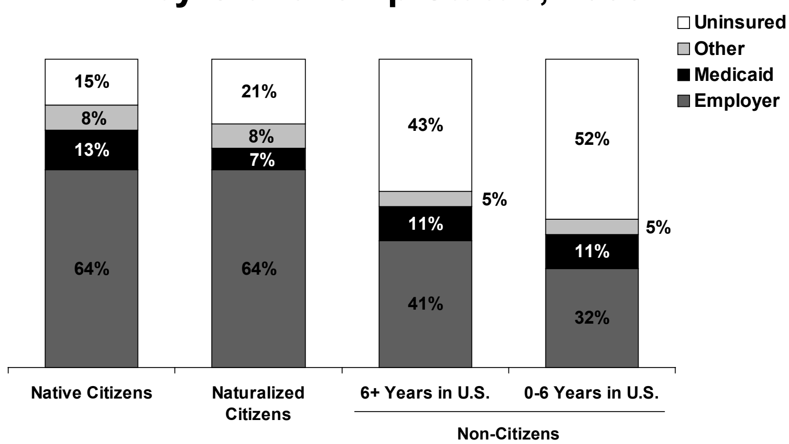
1 Technically, the term "immigrant" includes foreign-born persons who have not yet obtained citizenship status as well as those who have become naturalized citizens. As used in this report, the terms "immigrant" and "noncitizen" only refers to those immigrants who are not naturalized citizens.
2 The restrictions, with some modifications and additions, also were included in the Illegal Immigrant Reform and Immigrant Responsibility Act (IIRIRA) of 1996. Since 1996, Congress has amended the restrictions on several occasions, although few of these amendments apply to Medicaid. In this report, references to the PRWORA or welfare law restrictions include the IIRIRA modifications and additions and subsequent amendments.
3 Kaiser Commission on Medicaid and the Uninsured, "Health Insurance Coverage in America: 2003 Data Update," forthcoming 2004.

low-income uninsured children live in immigrant families. However, immigrants are not primarily responsible for the recent growth in the number of uninsured.[4]

- In 2003, between 43 and 52 percent of noncitizens lacked health insurance compared to 15 percent of native citizens (Figure 4).[5] Among low-income individuals (with incomes below 200 percent of the federal poverty level), between 58 and 65 percent of noncitizens lacked health insurance in 2003 compared to 28 percent of native citizens.[6]

Figure 4

Health Insurance Coverage by Citizenship Status, 2003



Notes: Based on nonelderly population. Other includes private non-group, Medicare, and CHAMPUS.
Source: Urban Institute and Kaiser Commission on Medicaid and the Uninsured analysis of March 2004 Current Population Survey.

- Over half of low-income noncitizen children and parents lacked health insurance in 2001. Noncitizen children were more than *three times* as likely to be uninsured as citizen children with citizen parents (Figure 5) and non-citizen parents were nearly twice as likely to be uninsured as U.S.-born parents.[7] Most children in low-income immigrant families are U.S. citizens. Citizen children with noncitizen parents have much higher uninsured rates than those in citizen families—26 percent versus 16 percent.[8]

[4] The Center for Immigration Studies — an organization that advocates for more restrictive immigration policies — has argued that immigration was a major reason for the increase in the number of uninsured in the 1990s. In fact, native-born U.S. citizens account for most of the increase in the number of uninsured. See John Holahan, Leighton Ku, and Mary Pohl, "Is Immigration Responsible for the Growth in the Number of Uninsured," Kaiser Commission on Medicaid and the Uninsured, February 2001.

[5] Kaiser Commission on Medicaid and the Uninsured, "Health Insurance Coverage in America: 2003 Data Update," forthcoming 2004.

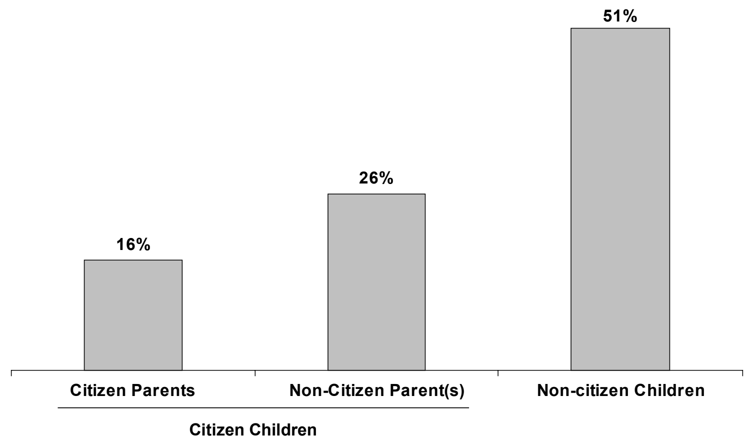
[6] Kaiser Commission on Medicaid and the Uninsured, "Health Insurance Coverage in America: 2003 Data Update," forthcoming 2004.

[7] Leighton Ku and Timothy Waidmann, "How Race, Immigration Status and English Proficiency Affect Insurance Coverage and Access to Care, " Kaiser Commission on Medicaid and the Uninsured, August 2003. See also, Leighton Ku, "Report Documents Growing Disparities in Health Care Coverage Between Immigrant and Citizen Children as Congress Debates Immigrant Care Legislation," Center on Budget and Policy Priorities, October 2003.

[8] Ibid at p. 3.

Figure 5

Uninsured Rates of Low-Income Children, by Citizenship Status, 2001



Note: Low-income means family income was under 200% of the poverty level, which was $30,520 for a family of three in 2003.
Source: Ku L, Waidmann T. "How Race/Ethnicity, Immigration Status and Language Affect Health Insurance Coverage, Access to Care and Quality of Care Among the Low-Income Population." Kaiser Commission on Medicaid and the Uninsured, August 2003.

Since 1995, the disparity in health coverage between immigrants and citizens has widened, and the number of low-income legal immigrants with health coverage has significantly declined. This decline in coverage rates for low-income immigrants occurred despite a modest increase in the share of low-income immigrants with employer-based coverage. These increases were more than offset by sharp declines in Medicaid and SCHIP coverage among noncitizens.

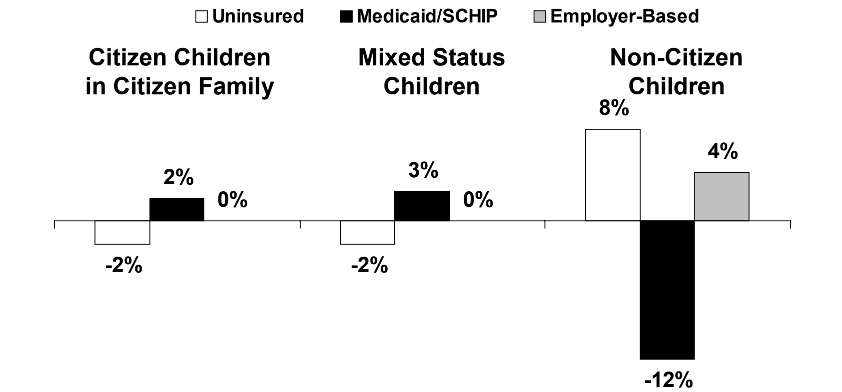
- Between 1995 and 2001, the proportion of low-income non-citizen children who were uninsured rose by 8 percentage points, accounting for an over 15 percent increase in the share of non-citizen children who were uninsured (Figure 6).[9] In contrast, uninsured rates among citizen children declined over this period. As seen in Figure 6, the increase in coverage among citizen children was driven by increases in Medicaid and SCHIP coverage. The decrease in coverage among non-citizen children was largely due to a significant drop in Medicaid and SCHIP coverage, which was partially offset by an increase in employer-sponsored insurance.

- Noncitizen parents also experienced a significant decline in coverage between 1995 and 2001. The proportion of uninsured non-citizen parents increased by 8 percentage points, compared to 3-4 percentage points for citizen parents (Figure 7).[10] As was the case with children, this decline was largely driven by a decrease in Medicaid coverage.

[9] Ibid. at p. 7.
[10] Ibid.

Figure 6

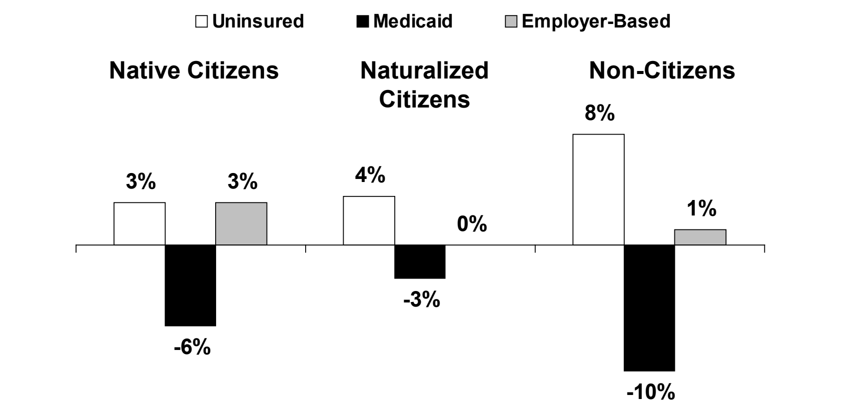
Percentage Point Change in Insurance Coverage for Low-Income Children, 1995-2001



Notes: Low-income is less than 200% of poverty. Beginning with the March 2001 Current Population Survey, the Census Bureau changes its method of determining who is uninsured. The new method, which is more accurate, adds a "verification question that asks whether a person is actually uninsured. Because "verified" data are not available for 1995, the changes shown here use "pre-verification" insurance data from the march 1996 and 2002 CPS.
Source: Ku and Waidmann, "How Race/Ethnicity, Immigration Status, and Language Affect Health Insurance Coverage, Access to Care, and Quality of Care Among the Low-Income Population," KCMU, August 2003.

Figure 7

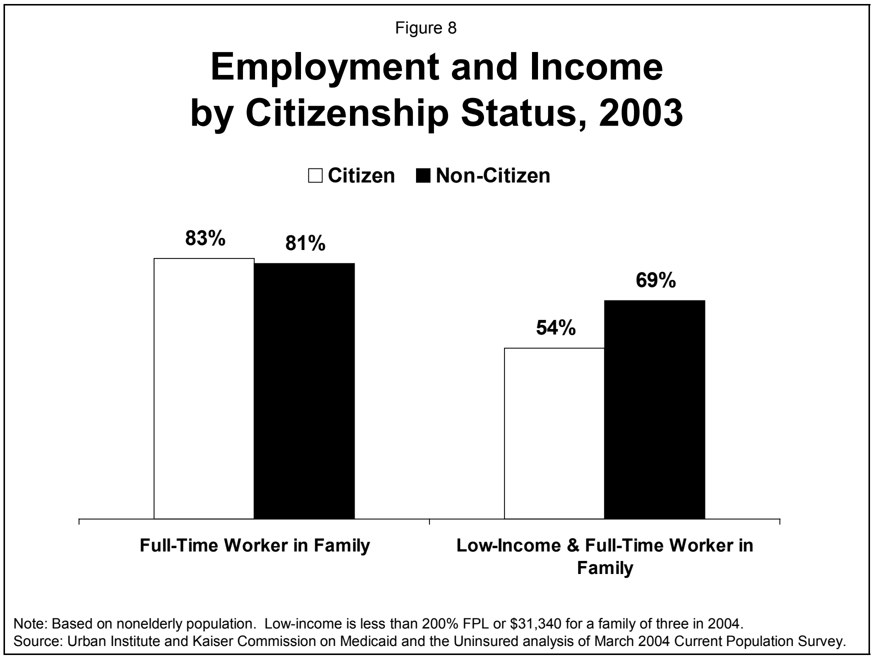
Percentage Point Change in Insurance Coverage for Low-Income Parents, 1995-2001



Notes: Low-income is less than 200% of poverty. Beginning with the March 2001 Current Population Survey, the Census Bureau changes its method of determining who is uninsured. The new method, which is more accurate, adds a "verification question that asks whether a person is actually uninsured. Because "verified" data are not available for 1995, the changes shown here use "pre-verification" insurance data from the march 1996 and 2002 CPS.
Source: Ku and Waidmann, "How Race/Ethnicity, Immigration Status, and Language Affect Health Insurance Coverage, Access to Care, and Quality of Care Among the Low-Income Population," KCMU, August 2003.

These disparities in coverage are not explained by differences in work effort. The vast majority of immigrants have a full-time worker in the family, but a disproportionate number of immigrants work in low-wage jobs, in small firms, and in labor, service, or trade occupations, which are less likely to offer health benefits.

- Over 80% of immigrants have a full-time worker in the family, and low-income immigrant families are more likely to include a full-time worker than low-income native families (Figure 8).[11]



- Hispanic noncitizens were half to two-thirds as likely to be offered insurance at the workplace as Hispanic citizen workers or white, non-Hispanic workers and fared worse than citizen workers with similar wages, hours, or occupations.[12]

- Immigrants are less likely to have employer-provided health insurance than native citizens. While nearly two-thirds of native citizens had health insurance through their employer in 2003, only between 32 percent and 42 percent of non-citizens had employer-based coverage.[13]

- Among children living in families with a full-time, year-round worker in 1997, 38 percent of noncitizen children were uninsured compared to 9.2 percent of citizen children with U.S.-born parents.[14]

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[11] Yuval Elmelech and others, "Children of Immigrants: A Statistical Profile" (New York City: National Center on Children in Poverty, September 2002).
[12] Claudia L. Schur and Jacob Feldman, "Running in Place: How Job Characteristics, Immigrant Status, and Family Structure Keep Hispanics Uninsured" (New York City: Commonwealth Fund, May 2001).
[13] Kaiser Commission on Medicaid and the Uninsured, "Health Insurance Coverage in America: 2003 Data Update," forthcoming 2004.
[14] E. Richard Brown, Roberta Wyn, and Victoria Ojeda, "Access to Health Insurance and Health Care for Children in Immigrant Families," (Los Angeles: UCLA Center for Health Policy Research, June 2003).

Immigrants without health insurance have less access to health care and are less likely to obtain needed care than immigrants with insurance. Lack of insurance has important health consequences and contributes to severe disparities in access to health care between immigrants and natives. Immigrants are less likely than other individuals to have a regular source of medical care, visit a doctor, or obtain preventive care.

- Noncitizens and their children are less likely to have a usual place where they can go for medical care, such as a doctor's office, HMO, or clinic, than other individuals, even after controlling for factors such as income, health status, and age.[15]

- Immigrants with health insurance are more likely to have access to health care at a doctor's office, HMO, or clinic, than immigrants without insurance. However, providing insurance does not eliminate all of the disparities in coverage between immigrants and citizens. Even when they have insurance, immigrants remain somewhat less likely to have a regular source of health care than citizens with insurance.[16]

- Noncitizens are less likely to have visited a doctor in the previous year than other individuals. For example, noncitizen children average about 1.5 provider visits a year while citizen children average over twice as many visits (3.7 visits). A substantial share of noncitizen children — 38 percent — had no doctor or health care provider visits in the previous year; only 13 percent of children of U.S. citizens did not see a doctor or other provider in the previous year.[17]

- Immigrant children are much less likely to have received hepatitis B or influenza immunizations than U.S.-born children.[18]

- A study examining differences in cervical cancer screenings among low-income women of reproductive age found that low-income Latina immigrants were less likely than other low-income women to have ever had a Pap smear.[19]

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[15] Leighton Ku and Sheetal Matani, "Left Out: Immigrants' Access to Health Care and Insurance," *Health Affairs* 20 (1) 2001: 249.
[16] Ibid.
[17] Ibid at p. 252.
[18] Tara W. Strine and others, "Vaccination Coverage of Foreign-Born Children 19 to 35 Months of Age: Findings From the National Immunization Survey, 1999–2000," *Pediatrics*, 110 (2) (2002).
[19] Isabel C. Scarini and others, "An Examination of Sociocultural Factors Association with Cervical Cancer Screening Among Low-Income Latina Immigrants," *Journal of Immigrant Health*, 5(3)(2003).

The Increasing National Importance of Immigrant Health Issues

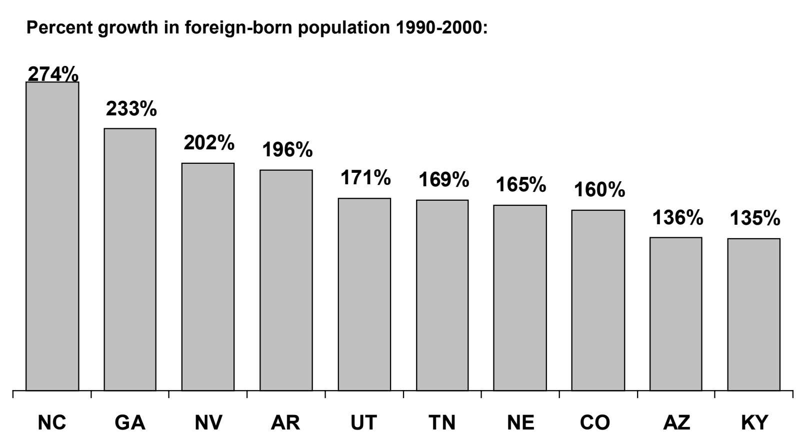
Immigrant health issues have often been viewed as a local concern for a few states and major urban areas, rather than a matter of widespread national importance. This is due in part to the relatively low levels of immigration for several decades prior to the 1980s and the concentration of immigrant populations in California, New York and a few other states. Major increases in immigration over the last 20 years and the increasing dispersion of immigration populations around the country now mean that immigrant health issues are truly a matter of national concern and increasingly important in all 50 states.

- Between 11 million and 14 million immigrants entered the United States during the 1990s, more than in any previous decade; immigration levels have tripled since the 1960s.[1]
- A substantial and growing share of children in the United States live in immigrant families. In 2000, nearly one in five children in the United States lived with at least one immigrant parent, and one in four poor children lived with an immigrant parent.[2]
- The immigrant population in states that have not been traditional destinations for immigrants grew quickly in the 1990s. Over two-thirds of immigrants live in six states (California, New York, Texas, Florida, New Jersey, and Illinois). However, other states—most in the Southeast and Moutain regions of the country—had the fastest growing immigrant populations (Figure 9).
- Changes in the demographics of the immigrant population have led to increasing linguistic and cultural diversity. Latin America and Asia have replaced Europe as the source of most immigrants; roughly half of all immigrants in 2002 were from Latin America and a quarter of all immigrants were from Asia.[3]

The Census Bureau projects that immigrants' share of the total U.S. population will continue to rise during the coming decade. By the middle of the century, the Census Bureau projects that immigrants will make up more than 13 percent of the total population — below the historical peak of 15 percent in 1890, but well above the 2000 level of around 10 percent.

Figure 9

States with the Highest Growth in Immigrant Population in the 1990's



Source: "The Dispersal of Immigrants in the 1990's", November 2002, The Urban Institute.

[1] Michael Fix, Wendy Zimmerman, and Jeffrey S. Passel, *Integration of Immigrant Families in the United States,* Urban Institute, July 2001, pp. 7-9.
[2] Yuval Elmel and others, "Children of Immigrants: A Statistical Profile" (New York City: National Center on Children in Poverty, September 2002).
[3] Bureau of the Census, *The Foreign-Born Population in the United States*, February 2003.

B. Categories of Immigrants

Immigrants living in the United States have one of the many dozens of immigration statuses or are undocumented. Their eligibility for public health coverage is tied to their immigration status. To simplify matters, this report groups the various categories of immigrants into four major groups that tend to be treated similarly for purposes of Medicaid and SCHIP eligibility (see text box).[20]

Categories of Immigrants for Purposes of Medicaid and SCHIP Eligibility

Lawful permanent residents (LPRs): LPRs are legal immigrants who generally are admitted to the United States to reunite with family members. Immigrants who have "green cards" are LPRs. There are two other significant avenues to LPR status. A U.S. employer can sponsor an individual for a specific position where there is a demonstrated absence of U.S. workers. In addition, diversity visas are provided to about 55,000 immigrants each year from countries that have been underrepresented due to immigration quotas.

Refugees, asylees, and other "humanitarian" immigrants: These are legal immigrants who have a well-founded fear of persecution in their home countries and were allowed either to emigrate to the United States or to obtain a lawful status if they were already in the United States. They generally can "adjust" to LPR status—refugees, for example, are able to adjust to LPR status after one year in the United States. As used in this report, the term "humanitarian immigrant" refers to any of the following immigrants: refugees, asylees, persons granted withholding of deportation, persons paroled into the United States for at least one year, persons granted conditional entry, Cuban/Haitian entrants, certain Amerasian immigrants, certain victims of a severe form of trafficking, and certain victims of domestic violence who are seeking legal status.

Other "lawfully present" or "lawfully residing" immigrants: Some immigrants are lawfully present or residing in the United States, but do not fit into either of the categories listed above. These immigrants may have any one of a variety of immigration statuses, including statuses that are temporary or pending. Examples include certain applicants for asylum and immigrants with temporary protected status (TPS). In the context of public benefits eligibility, many of the immigrants in this general category are referred to as "persons residing under the color or law" or "PRUCOL" immigrants.

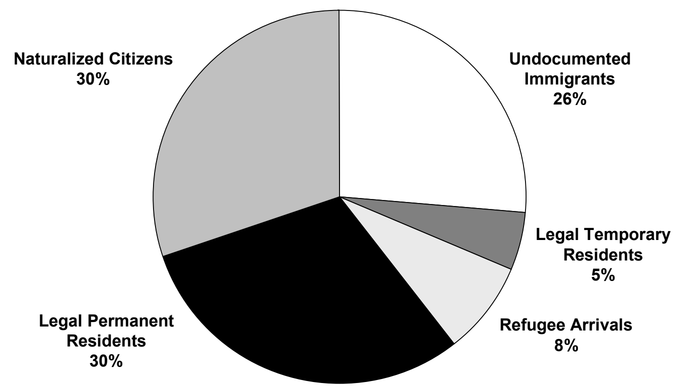
Undocumented immigrants: Undocumented immigrants either enter the United States without permission from immigration authorities or overstay their visas. They do not have legal status in the United States, although in some cases they may be eligible to adjust to a legal status.

[20] Immigrants in the first three categories are referred to in this report as "legal immigrants." The related term "qualified alien" is used in the welfare law and in many discussions of immigrant benefit eligibility. Immigrants in the first two categories are qualified aliens according to the welfare law's definition of the term. (See "Who is a Qualified Alien," Center on Medicare and Medicaid Services, www.cms.hhs.gov/immigrants/default.asp.) In this report, we generally avoid using the term "qualified alien," because it implies that all immigrants in these two categories are "qualified"—or eligible—for Medicaid and SCHIP, which is not the case. Status as a qualified alien is necessary, but not sufficient, to meet the immigrant eligibility requirements for Medicaid and SCHIP.

About 90 percent of legal immigrants enter the United States as either LPRs or refugees. LPRs and refugees generally can apply to become U.S. citizens after they have lived in the United States for five years. About 30 percent of all immigrants are LPRs, 30 percent are naturalized citizens, 26 percent are undocumented, 8 percent are refugees, and the remaining 5 percent have various other legal statuses (Figure 10).

Figure 10

Legal Status of the Immigrant Population, 2002



34.5 Million

Source: Passel, J., Capps, R., and M. Fix, "Undocumented Immigrants: Fact and Figures," The Urban Institute, January 2004.

III. PUBLIC HEALTH CARE COVERAGE FOR NONCITIZENS

Prior to the passage of the 1996 PROWRA welfare law, legal immigrants were eligible for Medicaid on the same basis as U.S. citizens if they met financial and other eligibility requirements. Federal law did not limit the eligibility of legal immigrants for Medicaid and states had no authority to establish eligibility rules that were stricter for legal immigrants than for U.S. citizens. The welfare law imposed unprecedented restrictions on legal immigrants' eligibility for various public benefits, including Medicaid. Most of the restrictions also apply to SCHIP, which was established in 1997.

Immigrants, both legal and undocumented, who meet all of the Medicaid eligibility requirements, except for the immigrant eligibility restrictions, can receive Emergency Medicaid if they need treatment for a medical emergency. Additionally, under federal law, hospitals are required to screen and stabilize all individuals, including immigrants, who seek care in their emergency room.

MEDICAID AND SCHIP

Medicaid is the largest publicly funded health care program in the United States. More than 38 million members of low-income families—and one out of every four children in the United States—receive comprehensive health coverage through Medicaid. In addition, about 12 million seniors and persons with disabilities are covered by Medicaid. The federal government and the states share the costs of Medicaid.

The State Children's Health Insurance Program (SCHIP) provides enhanced federal match funds to states to expand health insurance coverage to children. More than 5 million children receive SCHIP-funded health care coverage. Several states use SCHIP funds to expand Medicaid coverage for low-income children, generally by increasing income limits for Medicaid coverage. Other states use SCHIP funds for programs that are separate from Medicaid for low-income children who are not eligible for Medicaid.

Federal law does not prohibit states or localities from using their own funds to provide health insurance coverage to immigrants. Many states have used their own funds to provide the same health care coverage to some or all legal immigrants who are ineligible for Medicaid or SCHIP as they provide to U.S. citizens. Some states and localities also provide coverage to undocumented immigrants who are children or pregnant.

A. Medicaid and SCHIP Eligibility Rules for Immigrants

The basic Medicaid and SCHIP eligibility rules for immigrants are summarized in Table 1 and described in more detail below.

Table 1: Federal Medicaid and SCHIP Eligibility Rules for Immigrants

Immigrant Status	Eligible for Medicaid	Eligible for SCHIP	Eligible for Emergency Medicaid
LPRs who have resided in the U.S. for >5 years	✓	✓	N/A
LPRs who have resided in the U.S. for ≤5 years	No	No	✓
Refugees and other humanitarian immigrants[21]	✓	✓	N/A
Pregnant immigrants who are (1) LPRs and have resided in the U.S. ≤5 years, (2) "lawfully present," or (3) undocumented	No	✓	✓
"Lawfully present" immigrants who are not pregnant[22]	No	No	✓
Undocumented immigrants who are not pregnant	No	No	✓

Note: LPR is Lawful permanent resident. See text box on page 13 for a description of the immigration terms used in this table.

- **Legal immigrants who have resided in the United States for more than five years are eligible for Medicaid and SCHIP on the same basis as U.S. citizens.** There is one exception to this rule: certain "lawfully present" or PRUCOL immigrants are ineligible for Medicaid and SCHIP regardless of their length of residency in the United States. These immigrants account for a small portion of the overall population of legal immigrants.

- **Most recent legal immigrants who have resided in the United States for five years or less are subject to a "five-year bar" on Medicaid or SCHIP eligibility.** LPRs who enter the United States on or after August 22, 1996 are ineligible for Medicaid and SCHIP during their first five years in the United States. This rule is commonly referred to as the "five-year bar." After residing in the United States for five years, LPRs are eligible for Medicaid and SCHIP. LPRs subject to the five-year bar remain eligible for Emergency Medicaid.

[21] Two types of humanitarian immigrants — persons paroled into the United States for one year or more and certain victims of domestic violence — are subject to the same Medicaid and SCHIP eligibility rules as LPRs.
[22] Lawfully present immigrants who were receiving SSI on August 22, 1996 are eligible for Medicaid.

- **Refugees and most other humanitarian immigrants are not subject to the five-year bar on Medicaid and SCHIP eligibility.** Refugees and other humanitarian immigrants—except for parolees and domestic violence victims who are seeking legal status—are eligible for Medicaid and SCHIP regardless of their length of residence in the United States, even if they adjust their status and become LPRs. As such, if they meet financial and other eligibility requirements, they are eligible for Medicaid and SCHIP upon entry into the United States. In addition, LPRs and other lawfully present immigrants who are active-duty members or veterans of the U.S. Armed Forces, and their spouses and dependent children, are exempt from the five-year bar.

- **States may use SCHIP funds to provide prenatal care to pregnant women regardless of their immigration status.** CMS amended the SCHIP regulations in 2002 to establish this option.[23] Before the rule change, the SCHIP rules defined a child as an individual under age 19. CMS amended this definition to state that "under age 19" includes the "period between conception and birth." In essence, the rule change allows states to provide SCHIP-funded prenatal care without applying an immigration test, by extending eligibility to a pregnant woman's fetus, which does not have an immigration status and is not subject to the restrictions, rather than to the pregnant woman herself.[24]

- **"Lawfully present" immigrants are generally ineligible for Medicaid and SCHIP unless they adjust to LPR status, are granted asylum or some other humanitarian status, or are members or veterans of the U.S. Armed Forces.** Lawfully present immigrants remain eligible for Emergency Medicaid and states may use SCHIP funds to provide them with prenatal care. In addition, a small group of lawfully present immigrants who received SSI on August 22, 1996 remain eligible for Medicaid. Lawfully-present immigrants who adjust to LPR status are subject to the five-year bar if they entered the United States on or after August 22, 1996.

- **Undocumented aliens are ineligible for Medicaid and SCHIP—as they were prior to 1996**. However, they remain eligible for Emergency Medicaid. Also, as noted, states may use SCHIP funds to provide prenatal care regardless of the immigration status of the mother.

Federal law generally does not limit legal immigrants' eligibility for Medicare. In addition, all immigrants, regardless of immigration status, remain eligible for various public health programs, including maternal and child health clinical care, the Special Supplemental Program for Women, Infants and Children (WIC), and services for the prevention and treatment of communicable diseases.

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[23] See *Federal Register*, October 2, 2002, p. 61956.
[24] For a discussion of some of the issues involved in state-level implementation of the option, see "Prenatal Coverage for Immigrants through the State Children's Health Insurance Program" (Los Angeles: National Immigration Law Center, June 2003).

Senate Has Passed Bipartisan Legislation that Would Restore Medicaid and SCHIP Coverage for Some Legal Immigrants

The Immigrant Children's Health Improvement Act (ICHIA) would give states the option to provide Medicaid and SCHIP benefits to legal immigrants who are pregnant or children. The legislation has bipartisan support and was included in the Senate's Medicare prescription drug bill last year. An attempt to strip the provision from the Senate drug bill was defeated by a vote of 65 to 33 in the Senate, but the provision was not included in the final version of the bill signed by the President. The same provision will likely be offered as an amendment when the Senate takes up its version of the welfare reauthorization law, which may occur sometime in 2004 or 2005.

Legislation also has been introduced in Congress that would extend SSI and SSI-linked Medicaid eligibility for refugees and other humanitarian immigrants. Refugees and other humanitarian immigrants who entered the United States on or after August 22, 1996 (as well as a small number of immigrants who entered prior to that date) become ineligible for SSI and SSI-linked Medicaid at the end of their seventh year in the United States, unless they become naturalized citizens. About 2,000 refugees have already lost SSI eligibility because of this provision and several thousand more will lose eligibility over the next several months.

--For more information, see Shawn Fremstad, "The Impact of the Seven-Year Limit on Refugees' Eligibility for SSI," Center on Budget and Policy Priorities, May 2004.

B. State Authority to Impose More Restrictive Immigrant Medicaid Eligibility Rules than those Required by Federal Law

The welfare law gives states the authority to deny eligibility for Medicaid, including SCHIP-funded Medicaid expansions (but not separate state SCHIP programs), to certain LPRs even if they have lived in the United States for more than five years. States that decide to deny Medicaid eligibility must amend their state plans to reflect this decision.[25] States cannot impose immigrant eligibility rules in separate state SCHIP programs that are more restrictive than federal law. In addition, states cannot deny Medicaid to the following immigrants: naturalized citizens, refugees and other humanitarian immigrants (for the first seven years after refugee or some other humanitarian status is granted), legal immigrants who are active-duty members or veterans of the U.S. Armed Forces (and their children and spouses), and lawful permanent residents who can be credited with forty quarters of work in the United States (including quarters worked by a parent or spouse under certain circumstances).[26]

Although there is little question that the federal government can impose restrictions on legal immigrants' eligibility for public benefits, there are serious legal questions about whether the federal government can delegate authority to restrict legal immigrants' eligibility for public benefits to individual states. In 1971, the U.S. Supreme Court ruled that state-imposed restrictions on legal immigrants' eligibility for public benefits violate the equal protection clause of the U.S. Constitution.[27] The basic principle behind the Supreme Court ruling is that states do

[25] "State Medicaid Director Letter Regarding State Plan Process," Department of Health and Human Services, October 6, 1996.

[26] States also cannot deny Medicaid benefits to immigrants who were receiving SSI on August 22, 1996 for as long as they continue to receive SSI.

[27] *Graham v. Richardson*, 403 U.S. 365 (1971). In contrast, courts have upheld federally imposed restrictions on legal immigrants' benefit eligibility that apply regardless of an immigrant's state of residence, see, e.g., *Matthew v. Diaz*, 426 U.S. 67 (1976) and several cases upholding the immigrant eligibility restrictions on food stamps and SSI eligibility in the 1996 welfare law, including *City of Chicago v. Shalala*, 189 F.3d. 598 (7th Cir. 1999), cert. deined, 120 S.Ct. 1530 (2000).

not have the same power as the federal government to impose eligibility restrictions that discriminate against legal immigrants because the power to regulate immigration is almost exclusively federal.

Recently, New York's highest state court, relying in part on this precedent, ruled that the state cannot deny state-funded health care assistance to otherwise legal immigrants.[28] An attempt by Colorado to deny Medicaid to legal immigrants is currently the subject of litigation in federal court. Some have argued that state decisions to deny Medicaid to legal immigrants are constitutional because such decisions were specifically authorized by Congress in the 1996 welfare law. This argument was rejected in the recent New York decision. In that case, the New York Court ruled that Congress does not have the power to authorize state discrimination against legal immigrants, as the welfare law purports to do. The court's decision applies only to New York State, although it may influence decisions in other states. Ultimately, the legality of the provision in the welfare law authorizing state-imposed immigrant eligibility restrictions will remain in question in most states until the U.S. Supreme Court makes a decision on the matter that applies nationwide.[29]

C. Special Medicaid and SCHIP Eligibility Considerations for Immigrants with "Sponsors"

Many LPRs have "sponsors" who agree to help them settle in the United States. (Refugees and other legal immigrants do not have sponsors.) Sponsors are required by the federal government to sign a document known as an "affidavit of support" on behalf of the LPRs they sponsor. Having a sponsor does not make an LPR automatically ineligible for Medicaid or SCHIP. In some cases, however, the income and resources of an immigrant's sponsor may be counted in determining the immigrant's eligibility for Medicaid or SCHIP, regardless of whether the sponsor actually shares any of her or his income or resources with the immigrant. This procedure is known as sponsor-to-immigrant deeming or "sponsor deeming."

Sponsor deeming is a departure from normal eligibility rules, which typically only count income that is actually received by the immigrant. By attributing income to an immigrant that he or she has never received, deeming can push an immigrant over a state's Medicaid income or asset limits, even when they are very poor and have insufficient resources to pay for health care.

Sponsor deeming rules currently apply to few immigrants who are eligible for Medicaid or SCHIP. The number of immigrants potentially subject to deeming, however, will grow over time. Federal law limits sponsor deeming to LPRs who entered the United States on or after December 19, 1997 and signed documents known as "I-864 affidavits of support." Most LPRs with I-864 affidavits of support are subject to the five-year bar. As a result, few were eligible for Medicaid or SCHIP until December 19, 2002. Immigrants with I-864 affidavits of support are exempt from deeming if they fall into any of the following categories:

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[28] *Aliessa v. Novello*, 2001 N.Y. Int. 59 (June 5, 2001).

[29] For an in-depth discussion of these issues, see Michael J. Wishnie, "Laboratories of Bigotry? Devolution of the Immigration Power, Equal Protection, and Federalism," *New York University Law Review* (76: 493, May 2001).

- Immigrants who have become United States citizens (naturalized citizens);

- Immigrants who have worked or can get credit for 40 quarters of work, including quarters earned by a parent or spouse under certain circumstances;

- Certain immigrants who are victims of domestic violence;

- Immigrants who are unable to obtain food or shelter after taking into account their own income plus cash or in-kind assistance provided by the sponsor or others. States have flexibility to adopt an objective standard for making these determinations. Some states, for example, have adopted the standard used in the Food Stamp Program, which exempts immigrants from deeming if they have income under 130 percent of the federal poverty line.[30] States could adopt a higher standard in Medicaid.

In cases in which an immigrant lives with a sponsor, and the sponsor's income would be deemed to the immigrant under standard Medicaid income rules—for example, where the sponsor is a parent of a minor child or a spouse—the state can follow the standard rules rather than the sponsor deeming rules.

For those immigrants who are subject to deeming, the amount of income and assets that a state opts to deem will have a major impact on Medicaid and SCHIP access. The federal law does not proscribe any particular deeming methodologies; instead, states have flexibility to decide how much of a sponsor's income to deem.

D. Emergency Medicaid and the Emergency Medical Treatment and Active Labor Act

Immigrants, both legal and undocumented, who meet all of the Medicaid eligibility requirements, except for the immigrant eligibility restrictions, can receive Emergency Medicaid if they need treatment for a medical emergency. Thus, LPR's who are subject to the five-year bar, lawfully residing immigrants who are not eligible for Medicaid, and undocumented immigrants all may be eligible for Emergency Medicaid. For purposes of the Emergency Medicaid program, a medical emergency is any severe medical condition (including labor and delivery) for which the absence of immediate medical attention could place an individual's health in serious jeopardy, seriously impair bodily functions, or result in serious dysfunction of any bodily organ or part.

Emergency Medicaid is not available for immigrants who do not meet Medicaid financial and categorical eligibility requirements. However, under the Emergency Medical Treatment and Active Labor Act (EMTALA), hospital emergency departments must provide an appropriate medical screening examination to any patient who comes to an emergency department requesting examination or treatment for a medical condition. If the emergency department determines that the patient is suffering from an emergency medical condition, the hospital must provide patients with treatment until they are stabilized.

[30] Utah, for example, uses this standard in Medicaid.

EMTALA does not include funding to reimburse hospitals for the cost of providing emergency treatment. However, the Medicare prescription drug legislation enacted in 2003 included a provision offered by Senate Jon Kyl (R-AZ) that provides $250 million dollars a year for fiscal years 2005 to 2008 to health care providers for costs related to providing uncompensated emergency health services to immigrants who are undocumented, paroled into the United States to receive services, or to Mexican citizens with "border crossing" cards. An attempt in the U.S. House of Representatives to amend this provision to require providers to gather information about the immigration status of patients and transmit the information to the Department of Homeland Security was defeated in the House by an overwhelming bipartisan vote, with 331 House members voting against the amendment and 88 voting for it.

As of early September 2004, CMS had yet to issue final guidance on the implementation of this provision. In July 2004, CMS issued a draft of proposed implementation guidance that would have required hospitals to determine on a patient-by-patient basis whether each patient for whom they sought reimbursement was undocumented. This proposed requirement has been criticized by hospitals and hospital associations, health care advocates, and immigrant rights groups because of the burden it would place on health care providers and the possibility that many immigrants would decide not to seek emergency treatment if they know they will be asked questions about their immigration status.

IV. STATE RESPONSES TO MEDICAID AND SCHIP ELIGIBILITY RESTRICTIONS

The immigrant Medicaid and SCHIP eligibility restrictions were extremely controversial when they were adopted and have been viewed by many state policymakers and others as raising troubling equity and public health concerns. Many view the restrictions as inequitable because they bar legal immigrants—solely on the basis of their status as legal immigrants—from publicly funded programs despite the fact that they are obligated to pay federal taxes that support these programs and that they have complied with all federal immigration laws.[31] The public health concerns include not only concerns about the adverse impact of the restrictions on immigrants themselves, but also on the public in general. For example, research suggests that health care providers are adversely affected by high uninsured rates in the communities they serve and that these adverse impacts on providers can reduce access to various forms of medical care for entire communities, not just individuals without insurance.[32]

Responding to these concerns, many states now use state funds to provide the same or very similar health care coverage as they provide to U.S. citizens to some or all legal immigrants who are ineligible for Medicaid or SCHIP. In a few cases, the state-funded programs are more limited than Medicaid or SCHIP coverage.

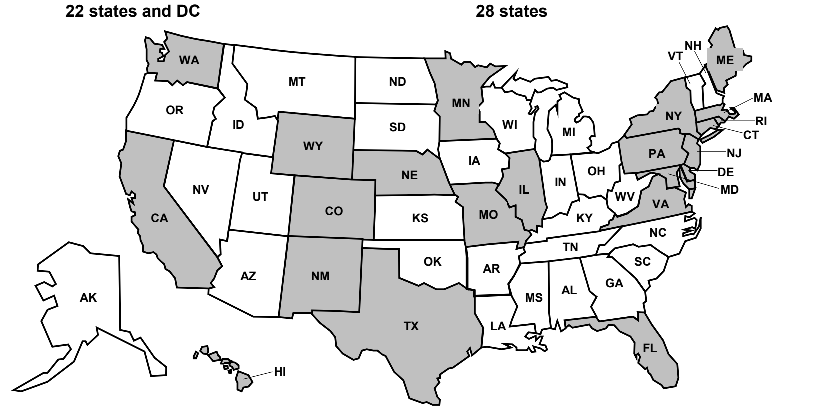
[31] In addition to paying taxes, legal immigrants generally have all the same civic responsibilities as citizens, including, for young men, the responsibility to register for the U.S. Selective Service. About 37,000 immigrants currently serve in the U.S. Armed Forced and another 13,000 noncitizens are members of the military reserves. At least 3,000 immigrants have served in the war in Iraq. See "AILA Calls on DOD Conferees to Support Immigrant Troops and Their Families," America Immigration Lawyers Association Press Release, November 11, 2003; "Proud to be an American: Immigrant Soldier Granted American Citizenship in Death," ABC News.com, April 8, 2004.
[32] See *A Shared Destiny: Effects of Uninsurance on Individuals, Families, and Communities* (Washington, DC: Institute of Medicine, March 2003), available at www.iom.edu/report.asp?id=5404.

A. State Funded Coverage for Immigrants who are Ineligible for Medicaid or SCHIP

As of 2004, 23 states used state funds to provide coverage to some or all immigrants who are ineligible for Medicaid and SCHIP because of their immigration status or because they have resided in the United States for less than five years (Figure 11). Table 2 (next page) lists these 23 states; provides information on whether the coverage is available to pregnant women, children, parents, and/or people with disabilities; and denotes when the state-funded coverage is more limited than Medicaid coverage. (See Appendix A for the income-eligibility limits for children and parents who are eligible for these programs.) Table 2 also includes the seven states that have used the option of providing SCHIP-funded coverage for prenatal care regardless of immigration status. These seven states include two states (Arkansas and Michigan) that do not provide any state-funded coverage for immigrants.

Figure 11

State-Funded Coverage for Immigrants Who are Ineligible for Medicaid or SCHIP, May 2004

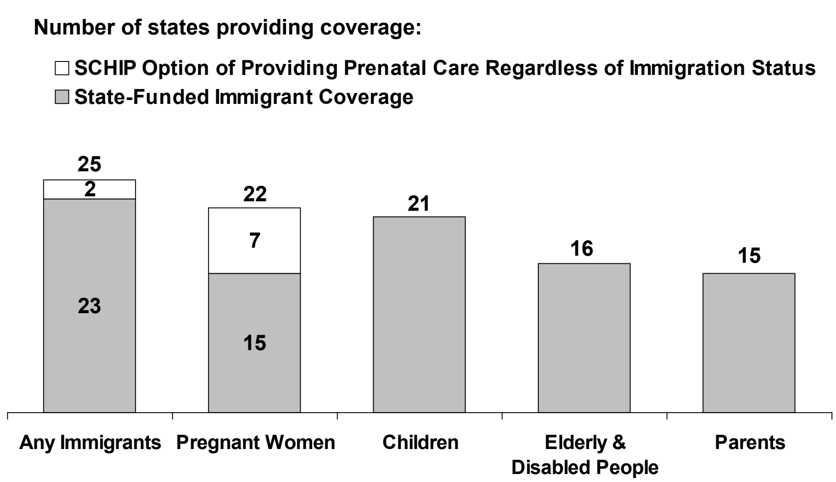


NOTES: In some cases coverage is only available to limited categories of immigrants and/or is substantially more limited than Medicaid or SCHIP coverage. Arkansas, Illinois, Massachusetts, Michigan, Minnesota, Nebraska, and Rhode Island use federal SCHIP funds to provide prenatal care coverage regardless of immigration status.

In total, 25 states provided state-funded coverage for immigrants and/or utilized the SCHIP option of providing prenatal care without regard to immigration status. States most commonly extended coverage to some or all immigrant pregnant women or children who would otherwise be ineligible for Medicaid or SCHIP (Figure 12). All of the states, except Massachusetts, that provided state funded coverage to seniors and people with disabilities also covered parents.

Figure 12

State Coverage for Immigrants, 2004



NOTE: State policies as of May 2004. Some states provide comprehensive coverage similar to Medicaid and SCHIP. Others provide reduced coverage or restrict coverage to certain immigrants within these categories.

Table 2: State Coverage for Immigrants, 2004

	Pregnant Women		Children		Parents	Elderly & Disabled People	Eligibility Notes (See Appendix B for an explanation of the immigration-status terms used below)
	State Funds	SCHIP Option	Medi-caid	SCHIP			
AR		✓		N/A			Prenatal care regardless of immigration status.
CA	✓		✓	✓	✓	✓	Qualified immigrants and PRUCOLs. SCHIP limited to qualified immigrants. Prenatal care and long-term care provided regardless of immigration status.
CO	✓						Qualified immigrants and other lawfully present immigrants.
CT	✓		✓	✓	✓	✓	Qualified or other lawfully residing immigrants.
DE	✓		✓		✓	✓	Qualified or other lawfully residing immigrants. Subject to availability of state funds, but funding has been sufficient to serve all eligible persons who have applied for coverage.
DC	✓		Cap	N/A	R	R	Children regardless of immigration status; capped at around 800 children; current one to two month waiting list. Other immigrants, regardless of immigration status, eligible for DC Healthcare Alliance, which provides limited benefits.
FL				Cap			Children regardless of immigration stats. Funding is capped; current waiting list.
HI	✓		✓	N/A			Lawful permanent residents who arrived on or after August 22, 1996, PRUCOL immigrants, and children who are citizens of the Freely Associated States.
IL		✓	✓	✓	L	L	Prenatal care regardless of immigration status. Children who are qualified immigrants or lawfully residing immigrants. Other qualified immigrants who are victims of domestic violence.
ME	✓		✓	✓	✓	✓	Qualified immigrants and PRUCOLs.
MD	✓		✓	✓			Qualified immigrants.
MA		✓		✓	L	Cap	Prenatal care and children's coverage regardless of immigration status with cost-sharing for those with incomes over poverty level. Coverage for most disabled or elderly qualified immigrants and PRUCOLs ends September 2004. Some disabled or elderly immigrants are eligible for a more limited basic health benefit. Certain "grandfathered" immigrants who were receiving Medicaid or in a nursing home on June 30, 1997are eligible for the same coverage available to citizens under Medicaid.
MI		✓					Prenatal care regardless of immigration status.
MN		✓	✓	N/A	✓	✓	Prenatal care and victims of torture regardless of immigration status. Other qualified immigrants and other lawfully residing immigrants.
MO	✓			N/A			Prenatal care regardless of immigration status.
NE		✓	✓	N/A	✓	✓	Prenatal care regardless of immigration status. Other qualified immigrants.
NJ	✓		✓	✓		L	Prenatal care regardless of immigration status. Other qualified immigrants. PRUCOLs in Medicaid-approved nursing homes prior to January 29, 1997 remain eligible for nursing home care.
NM	L		L	N/A	L	L	PRUCOLs that arrived prior to August 22, 1996.
NY	✓		✓	✓	✓	✓	Qualified immigrants and PRUCOLs. No immigration test for pregnant women seeking prenatal care or children.
PA	✓		✓	✓	✓	✓	Qualified immigrants and PRUCOLs.
RI		✓	✓	N/A	L	L	Prenatal care and children's coverage regardless of immigration status. Other adults who are lawfully residing immigrants who resided in the U.S. prior to August 22, 1996 and were residents of Rhode Island prior to July 1, 1997.
TX				✓			Qualified immigrants.
VA			✓				Qualified immigrants and PRUCOLs.
WA	✓		R		R	R	Pregnant women regardless of immigration status. Legal immigrant adults and all immigrant children are eligible for Basic Health, which has limited benefits, cost-sharing, and a waiting list.
WY	L		L		L	L	Certain qualified battered immigrants and immigrants paroled into the U.S. for more than one year. Coverage for the latter group is limited to one year.
TOTAL	15	7	19	11	15	16	

See Appendix B for Table Notes.
✓: Provides same or very similar services as Medicaid or SCHIP to all qualified immigrants who are ineligible for federally funded Medicaid and has no cap on number that may be served or funds that may be expended.
Cap: Program provides same or very similar services as Medicaid or SCHIP subject to a cap on enrollment or funding.
L: Provides same or very similar services as Medicaid or SCHIP to very limited categories of immigrants.
R: Provides reduced benefits compared to Medicaid. It may have premiums and cost-sharing requirements and/or a cap on enrollment or funding.
N/A: State uses SCHIP dollars to expand Medicaid and does not have a separate SCHIP program.

Most of the state-funded programs for immigrants had the same scope of coverage and rules as Medicaid (or SCHIP). However, some states only provided the coverage to very limited categories of immigrants and a few states provided health coverage that is significantly more limited than the coverage available under Medicaid or SCHIP or that has other restrictions and rules that may limit participation by eligible immigrants. Such restrictions may include cost sharing, monthly premiums, more burdensome enrollment procedures, and caps on funding or enrollment.

- Florida provides state-funded SCHIP coverage to children regardless of immigration status, but more than 20,000 immigrant children were on a wait list for coverage in March 2004. The legislature appropriated funds this year to eliminate this wait list as well as a larger waiting list for federally-funded SCHIP, but enrollment for new applicants has been frozen since then.[33]

- Immigrants in Washington State who are ineligible for Medicaid are eligible for the state's Basic Health program. Basic Health services are more limited than Medicaid, enrollment is capped, and families must pay premiums and co-pays. Previously, Washington provided state-funded coverage to immigrant families that was the same as the coverage provided under Medicaid. In 2002, the state decided to eliminate the state-funded Medicaid program and provide coverage to immigrant families through the Basic Health program. A recent report found that almost half of the immigrants who lost state-funded Medicaid did not transition to Basic Health, reflecting difficulties completing enrollment procedures and affording premiums.[34]

- Wyoming's immigrant coverage is only available to certain qualified battered immigrants and immigrants paroled into the United States for more than one year. Coverage for the paroled immigrants is limited to one year.

Most state-funded programs for immigrants were created within a year or two after passage of the federal welfare law, a period when state economies were strong and many states had substantial budget surpluses. More recently, the recession and other factors have contributed to serious fiscal problems in many states. As a result, a few states have cut or considered cutting state-funded health care programs for legal immigrants. As noted above, Washington eliminated its state-funded Medicaid program for legal immigrants and now covers immigrants in its more limited Basic Health program. In recent legislative sessions, Connecticut, Massachusetts, and New Jersey eliminated some of their state-funded programs. Connecticut reversed the cuts to its state-funded programs earlier this year. Massachusetts has reversed some of its cuts for short periods of time; earlier this year, the Governor vetoed legislation that would provide long-term authorization for the immigrant program.[35]

However, even during this period of fiscal stress, some states have expanded coverage. Earlier this year Arkansas used SCHIP funds to extend prenatal care to undocumented and other

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[33] "Update on the SCHIP Enrollment Freeze," Kaiser Commission on Medicaid and the Uninsured, July 2004.
[34] Mark Gardner and Janet Varon, "Moving Immigrants from a Medicaid Look-Alike Program to Basic Health in Washington State: Early Observations," Kaiser Commission on Medicaid and the Uninsured, May 2004.
[35] See Ali Noorani, "Romney dims state's beacon to immigrants," Boston Globe, July 18, 2004.

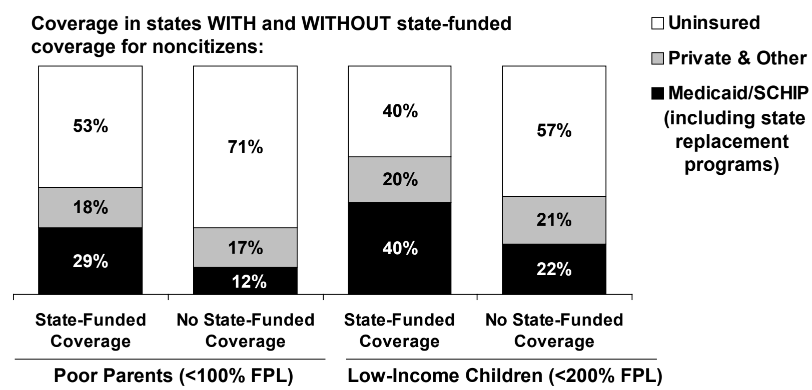
immigrants who are ineligible for Medicaid because of their immigration status or length of residency in the United States. Illinois recently extended state funded coverage to qualified immigrants who are victims of domestic violence but ineligible for Medicaid because of the five-year bar.

B. Immigrants are More Likely to be Insured in States with State-funded Programs

Analysis recently conducted by the Center on Budget and Policy Priorities compares uninsured rates for noncitizens in states with state-funded replacement programs for immigrants to uninsured rates in states without such programs.[36] The analysis finds that noncitizens living in states with replacement programs have *significantly lower uninsured rates* than such noncitizens living in states without replacement programs (Figure 13). The difference in uninsured rates is entirely due to the higher rate of enrollment in Medicaid or SCHIP (including Medicaid and SCHIP replacement programs for noncitizens) in the states with replacement programs. There is no significant difference in insurance coverage rates outside of Medicaid and SCHIP—employer-based or private coverage, and other forms of public coverage such as Medicare or veterans' benefits—between the two groups of states.

Figure 13

Health Insurance Coverage Among Noncitizen Parents and Children, 2002



Note: Analysis excludes states that have state-funded programs that are more limited than Medicaid, are subject to enrollment or funding caps, or provide coverage to limited types of legal immigrants who are ineligible for Medicaid. States excluded completely from the analysis of children's coverage are the District of Columbia, Florida, New Mexico, and Texas. The District of Columbia, Illinois, Massachusetts, New Mexico, and Rhode Island were excluded from the analysis of parents. Other coverage includes private coverage and other public coverage, including Medicare and Veterans' benefits.
Source: Center on Budget and Policy Priorities' analysis of Mach 2003 Current Population Survey Data.

Additional analysis attempted to determine whether the higher coverage rate for noncitizens in states with replacement programs was the result of higher overall Medicaid and SCHIP coverage rates for all low-income families in those states. This analysis compared: 1) the difference in coverage rates between citizens and noncitizens in states with replacement programs to 2) the difference in coverage rates between citizens and noncitizens in states without such programs. The resulting figure — the "difference in the differences" — effectively controls for the fact that coverage rates for all low-income families (citizen and noncitizen) in states with replacement programs may be higher than coverage in states without such programs.

[36] Excluded from the analysis are states that have state-funded programs that are more limited than Medicaid, are subject to enrollment or funding caps, or provide coverage to limited types of legal immigrants who are ineligible for Medicaid. The states that have been excluded completely from the analysis are the District of Columbia, Florida, New Mexico, and Texas. The District of Columbia, Illinois, Massachusetts, New Mexico, and Rhode Island were excluded from the analysis of parents' uninsurance rates.

In states with replacement programs, the difference in coverage rates between low-income citizen and noncitizen *children* was significantly less than the difference in coverage rates in states without replacement programs. This suggests that state replacement programs do increase the coverage rate of noncitizen children. The difference in coverage rates between poor citizen and noncitizen *adults* also was less in states with replacement programs than in states without such programs, but the difference in the differences was not statistically significant. It still seems likely that adult noncitizens living in states with replacement programs are less likely to be uninsured. However, the magnitude of the difference in uninsured rates in these states is not large enough to be confident that the difference is not due to sampling error.

Higher rates of coverage for immigrants in states with replacement programs may be due not only to the replacement programs, but also to other differences that are related to immigrants' willingness to participate in public programs in those states. States with state-funded programs may tend to have more "immigrant-friendly" environments in their public assistance offices and may have done more to publicize the availability of benefits — particularly benefits for children — to immigrant communities. They may also have taken greater actions to reduce immigrant-specific enrollment barriers, which are discussed in greater detail below.

C. Few States Have Adopted More Restrictive Eligibility Rules

As previously noted, the welfare law allows states to adopt more restrictive immigrant eligibility rules in Medicaid than the federal restrictions for immigrants who are not refugees, asylees, veterans, who cannot claim 40 quarters of work in the United States, or who are not SSI recipients. Few states have adopted such restrictions. Only two states, Colorado and Wyoming, place additional restrictions on Medicaid coverage for legal immigrants regardless of their date of entry to the United States and length of residence.[37] In response to a fiscal crisis, Colorado imposed its restrictions in 2003. A federal court initially barred implementation of these restrictions pending a decision on their legality, but later allowed them to be implemented while the litigation moves forward. Earlier this year, however, the Colorado Legislature lifted its restrictions on coverage for legal-immigrant children.

Federal law does not give states authorization to deny coverage to legal immigrants based on the date they entered the United States.[38] Nevertheless, five states that provide Medicaid coverage to legal immigrants impose unauthorized restrictions based on date of entry. In these states, immigrants who entered the United States prior to August 22, 1996 are eligible for Medicaid, but legal immigrants who entered the United States on or after August 22, 1996 do not appear to be eligible for Medicaid even if they have lived in the United States for five or more years. In at

[37] Wyoming limits federal Medicaid coverage to the various categories of immigrants it is required to cover under federal law.

[38] CMS guidance explains that if a state extends coverage to all qualified immigrants who entered the United States prior to August 22, 1996, it also must extend coverage to all qualified immigrants who enter on or after that date and have reached the end of the five-year bar. "Questions and Answers on the Five-year Bar," U.S. Department of Health and Human Services, www.cms.hhs.gov/immigrants/alien2.pdf. Thus, all qualified immigrants who reach the end of the five-year bar should be eligible for Medicaid in every state but Wyoming. In addition, as discussed in Section III.B., a state's decision to restrict eligibility based on an immigrant's date of entry would appear to violate the U.S. Constitution under the Supreme Court's decision in *Graham v. Richardson.*

least some of these states, it is unclear whether the state has made an affirmative decision to restrict coverage.

V. REDUCING ENROLLMENT BARRIERS FOR IMMIGRANTS

Many low-income legal immigrants are not subject to the five-year bar or other federal restrictions and remain eligible for Medicaid or SCHIP. In addition, most children living in immigrant families are U.S. citizens and remain eligible for Medicaid and SCHIP regardless of their parents' immigration status. Despite being eligible for coverage, however, many of these individuals are not enrolled in Medicaid or SCHIP.

To some extent this is due to barriers to obtaining coverage that apply to both immigrant and native families. Working parents, in particular, often do not know about Medicaid and SCHIP, or they believe that because they have a job their children do not qualify. Many do not know how to apply for benefits, or find the application process too complicated or inconvenient for a working family's schedule. Although much work remains to be done, considerable progress has been made on reducing some of these general barriers and over the past several years extensive outreach campaigns have helped to publicize the availability of coverage.

Immigrant families face additional barriers to coverage that relate specifically to their status as immigrants. These barriers include:

- Confusion about program eligibility rules for immigrants and citizen children living with immigrants;
- Concern that receiving Medicaid or SCHIP will have adverse immigration consequences—in particular, many immigrants worry that receiving benefits will make them a "public charge," a designation that could make it difficult to adjust status or re-enter the country after time outside the U.S.—or that benefit receipt will prevent an immigrant from sponsoring a relative seeking to emigrate to the United States; and
- Unnecessary requests for sensitive information, such as Social Security Numbers (SSNs) or immigration status, from household members who are not seeking benefits for themselves.

As explained below, recent policy clarifications, as well as other longstanding policies that often are not well-understood, help address many of these concerns. There is evidence, however, that some of these policies have not been uniformly implemented. Even where these policies are in place, a major challenge remains to inform immigrants and their families that they may be eligible for coverage, and that receipt of Medicaid, SCHIP, or other health care assistance will not have negative repercussions.[39]

On a more positive note, there is some evidence that recent aggressive child health outreach efforts, many targeted at immigrant and minority children in particular, in combination with the policy clarifications discussed below, have been effective. Most notably, among low-income citizen children with at least one non-citizen parent, uninsured rates decreased from 29 to 22

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[39] For more information on designing health outreach to immigrants, see National Immigration Law Center, "Immigrant-Friendly Health Coverage Outreach and Enrollment," National Immigration Law Center, June 2002.

percent and Medicaid and SCHIP coverage rates increased from 34 to 42 percent between 1999 and 2002.[40] While Medicaid and SCHIP coverage for noncitizen children fell during the same period, the declines may have been even greater in the absence of such efforts.

A. Addressing Confusion about Eligibility

Given the complexity of the immigrant eligibility restrictions, and the substantial variation among states in eligibility rules, it should come as no surprise that many immigrants, service providers and government agencies are confused about who is eligible for Medicaid or SCHIP. In addition, many immigrants are anxious not to act in ways that will bring disapproval in their new country and may fear that receipt of means-tested benefits may bring such disapproval. A California study, for example, found that Spanish-speaking Latinos (who tend to be immigrants) are much more likely than non-Latinos and English-speaking Latinos to say that they don't want to enroll their children in a government program.[41]

Since the eligibility restrictions were put in place, a variety of outreach and education efforts have provided information about immigrants' eligibility for various health care programs. In some cases these efforts have been targeted specifically at immigrant families; in other cases they have been part of broader outreach campaigns, typically targeted at low-income working families. For example, the Illinois Department of Human Services provides funding to a coalition of 34 organizations serving immigrant families, known as the Outreach and Interpretation Project, to inform these families about the availability of public benefits and to provide them with assistance in applying. Through this project, immigrant families are provided with program information, referrals, interpretation and translation assistance, and case management.

B. Reducing Language Barriers

It is especially important to provide information in the language spoken by members of the immigrant community on program eligibility rules for immigrants and to address common concerns that immigrants may have about securing access to benefits. Language barriers can prevent immigrants from learning that coverage is available or understanding how to apply for it, and can also make it difficult for immigrants to retain coverage, particularly if renewal notices are not available in their primary language. Even after an application for health care or other public benefits is submitted, many immigrant families are likely to need additional help with the process. It is common for families to receive notices requesting additional information. They may put aside letters they cannot read and, as a result, have their application denied or benefits terminated. A California study surveyed parents who requested, but did not complete, an application for one of the state's health care programs. Spanish-speaking Latinos were more likely than English-speaking Latinos and non-Latinos to fail to complete the application and to miss deadlines for submitting required documentation.[42]

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[40] Randy Capps, Genevieve Kenney, and Michael Fix, "Health Insurance Coverage of Children in Mixed-Status Immigrant Families," Urban Institute, 2003.
[41] "Barriers to Enrollment in Healthy Families and Medi-Cal: Differences by Language and Ethnicity" (San Francisco: Institute for Health Policy Studies, University of California, February 2001).
[42] Ibid.

Reducing Language Barriers in Minnesota

Minnesota has taken extra steps to assist families that may be deterred from enrolling in coverage due to language barriers. The state's application for health care programs is offered in 10 languages other than English and the application form bears a notice written in those 10 languages about the availability of alternate applications. In addition, the first three questions of the application ask families about their preferred written and spoken language and whether they would like to request an interpreter. All 11 versions of the application, as well as translated versions of the health coverage renewal form, are available on the state Department of Human Services website.

Outreach workers often address these issues by showing family members who cannot read English well how to recognize the return address of the public benefits agency and encouraging these families to call the outreach workers promptly for help in interpreting notices they receive. In some areas, outreach workers and others can be designated as authorized representatives, and as such, receive copies of all notices sent to a family.

Long-standing federal policies under Title VI of the Civil Rights Act require states and other entities that receive federal Medicaid and SCHIP funds — including Medicaid and SCHIP eligibility offices—to provide assistance to individuals with limited English proficiency (LEP).[43] It is worth noting, however, that an increasing number of states and localities have developed written policies that require welfare agencies to provide language assistance to LEP persons.[44] These policies are designed to ensure compliance with Title VI requirements and typically require that agencies:

- assess the language needs of LEP clients;
- provide interpreters to LEP clients and hire bilingual staff;
- not rely on family members or friends of an LEP client's family to interpret, except in limited cases where a client prefers to rely on a family member or friend in place of free language services affirmatively offered by the agency;
- adopt procedures to ensure timely and effective telephone communication;
- inform clients of their right to language assistance;
- translate application forms and other written materials into appropriate languages; and
- train staff on LEP policies and procedures.

In addition, some states have adopted standards that require local offices to hire bilingual workers, as well as to implement programs designed to ensure the quality of oral interpretation and written translations.

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[43] HHS recently issued updated guidance on LEP access. See "Guide to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons," U.S. Department of Health and Human Services, August 2003, www.hhs.gov/ocr/lep/revisedlep.html.

[44] See, for example, Minnesota's plan at www.dhs.state.mn.us/Language/default.htm and Washington State's policy at www1.dshs.wa.gov/ESA/EAZManual/Sections/LEP.htm.

Efforts to Serve People with Limited English Proficiency (LEPs) in Washington State

Washington State has standards that require the hiring of bilingual caseworkers when the number of LEP cases in a local office reaches a specified level. All bilingual staff, interpreters, and translators must be certified or qualified by passing a state bilingual fluency test. All bilingual staff and interpreters must abide by a code of professional conduct that includes a requirement to maintain client confidentiality and can be decertified if they fail to do so.[1] Certified bilingual staff receive a five-percent salary increase.

Washington also has extensive procedures for translation of written materials. All written notices and major written communications are automatically translated into the seven most commonly encountered languages. There is also a process for translating written notices and major communications into most other languages, regardless of the size of the language group involved. In a typical month, written notices are translated by contractors into 60 to 70 different languages.

[1] Washington State, Administrative Code, 383-03-050.

C. Addressing "Public Charge" Concerns

Many legal immigrants fear that if they receive various public benefits, immigration authorities will decide they are likely to become a "public charge" (i.e., dependent on government benefits for their long-term economic support). A public charge finding may result in denial of permission to adjust to legal permanent resident status, denial of a visa to enter the United States, denial of re-admission to the United States after a trip abroad for more than six months, or, in very rare circumstances, deportation.

In 1999, the federal government issued guidance that narrowly limits the situations in which receipt of public benefits is relevant to a "public charge" finding.[45] Under the guidance, receipt of non-cash benefits, including Medicaid, SCHIP, and health care benefits funded under a state replacement program, is never a factor in a public charge determination.[46] As a result, immigrants can accept Medicaid, SCHIP and other health care benefits without endangering their immigration status.[47] Many immigrants, however, still incorrectly believe that there may be adverse immigration consequences associated with receiving publicly funded health care benefits.

In addition, some immigrants and U.S. citizens who hope to sponsor relatives to enter the United States may believe that receiving Medicaid or SCHIP could cause immigration authorities to reject them as sponsors. The federal guidance addresses this concern by stating that INS will not hold receipt of means-tested benefits against a prospective sponsor.

Despite the guidance, many immigrants remain confused about whether receiving Medicaid or SCHIP will make them a public charge. A California survey, conducted after the guidance was

[45] The Bureau of Citizenship and Immigration Service, formerly the Immigration and Naturalization Service, has a fact sheet on the guidance at www.immigration.gov/graphics/publicaffairs/factsheets/public_cfs.htm

[46] There is one very limited exception to this rule. Institutionalization for long-term care at government expense may be considered for public charge purposes. Short-term stays for rehabilitation purposes at long-term care facilities, however, are not a factor in a public charge determination. As a practical matter, immigrants who are institutionalized for long-term care are unlikely to be subject to public charge determinations. For a detailed discussion, see Shawn Fremstad, *The Applicability of Public Charge Rules to Legal Immigrants who are Eligible for Public Assistance,* Washington, DC: Center on Budget and Policy Priorities, April 2004.

[47] Ibid.

issued, found that nearly 20 percent of Spanish-speaking Latinos who requested Medicaid applications decided not to complete them because they were concerned that receiving benefits would have an adverse effect on their immigration status.[48] Community education can help reduce these concerns by making extra efforts to reassure immigrants that health care benefits are not a factor in public charge determinations.

Medicaid applications in several states—including Iowa, Idaho, New York, and Texas—contain helpful language telling immigrants that receiving Medicaid or SCHIP will not affect their immigration status. In Idaho and Texas, for example, this language is included with other immigrant-specific information on the first page of the application.

D. Reducing Improper Requests for Sensitive Information from Non-applicants

Many children eligible for Medicaid or SCHIP live with parents or other household members who either are undocumented or whose immigration status renders them ineligible for benefits. Often state agencies ask for sensitive information, such as immigration status or SSNs, about these family members during the application process, even when these ineligible family members are not applying for benefits for themselves and the information is not relevant to the actual applicant's eligibility. Some applications even ask whether household members, including those not seeking benefits, are "illegal" or "undocumented" immigrants. Although federal rules allow immigrants *not* to specify the immigration status or the SSN of family members not seeking benefits, this is not widely known and some states have yet to conform their application forms to the federal requirements.

Under Medicaid and SCHIP rules, applicants are able to designate which individuals in the family or household are seeking coverage and which individuals are not seeking coverage. States can only require applicants who are seeking Medicaid or SCHIP for themselves to provide their SSNs and immigration status information. States *cannot* require applicants to provide SSNs or immigration status information for family or household members who are not seeking benefits for themselves.[49]

While federal guidance provides that states may ask non-applicant family members to *voluntarily provide* SSNs, it also cautions states against doing so, noting that "in order to avoid potential violations of the Privacy Act, states should not require non-applicants to disclose their SSNs as a condition of applicants' eligibility for these benefits." If a state ignores this warning and requests SSNs from non-applicants, under the federal Privacy Act the agency must provide notice that disclosure is voluntary and identify the uses that will be made of the number.

Several states have modified their applications to comply with these requirements. Such applications allow the person completing the application to designate which household members are seeking benefits for themselves. Household members not seeking benefits are not asked to provide SSNs or to disclose their immigration status. New York's application, for example, includes the following elements:

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[48] Institute for Health Policy Studies, "Barriers to Enrollment in Healthy Families and Medi-Cal."
[49] See Department of Health and Human Services and Department of Agriculture, "Guidance on Inquiries Into Citizenship and Immigration Status" (revised January 31, 2003), www.hhs.gov/ocr/nationalorigin/ocrguidance.html.

- The application asks the person completing the form to list members of their household and place a check next to the names of household members who want health insurance.[50]
- In a separate "Applicants Only" section, a line is provided on which to insert SSNs *only* for household members who have been identified as wanting health insurance. This section of the application makes clear that an SSN is not needed for pregnant women.
- In a separate section of the application on "Citizenship," the application asks for information on household members who want health coverage and are not U.S. citizens. Next to the name of household members who want health coverage and who are not U.S. citizens, the person completing the application checks a box indicating whether the person's immigration status falls into one of two categories, based on a list provided. If the person's status does not fall into one of these categories the box labeled "none" is checked. This method allows the state to determine whether the applicant can be covered under Medicaid or SCHIP or under its state-funded program without requiring the person completing the form to reveal if the applicant is undocumented.

A related problem involves applications that include requests for other kinds of unnecessary information that may deter participation by immigrant families. Examples include applications that ask for the country of birth or port of origin of all immigrants in the household. Such information—from either applicants or non-applicants—is irrelevant to program eligibility. Similarly, some applications include language requiring the person completing application to "certify, under penalty of perjury that each person included in the household is a U.S. citizen or alien in lawful immigration status." A less intimidating approach involves simply asking applicants to certify that the information they provided in the application—including the immigration status of those household members seeking benefits for themselves—is true.

Tennessee: A "New Immigrant" State Adopts Policies Designed to Ensure that Immigrant Families have Equal Access to Medicaid and Other Programs

Tennessee's immigrant population, like that of many other southern states, increased dramatically in the 1990s. At the same time, there were increasing reports that immigrant families were being incorrectly denied Medicaid and other public benefits or turned away from applying. Problems included failures to provide interpreter services, the denial of benefits to eligible household members if non-applicant members of their households did not provide SSNs, threats by some caseworkers to report immigrants to the INS if they applied for benefits for their citizen children, and the denial of Emergency Medicaid to eligible immigrants.

In response to these problems, the Tennessee Department of Health Services (TDHS) issued a series of policy bulletins containing guidance designed to improve immigrant families' access to Medicaid and other programs. The guidance explains that household or family members who are not applying for benefits for themselves do not have to provide SSNs or information about their immigration status, clarifies that Medicaid receipt is not relevant to public charge determinations, and provides guidelines for providing language assistance to LEP individuals. TDHS attaches a notice of these policies to all its public benefit applications.

--For more information and links to the Tennessee policies, see Chris Griffin, "Immigrant Access to Public Benefits: Tennessee Immigrant Groups Help Create Comprehensive Policies to Ensure Equal Access to Medicaid, Food Stamps and TANF," *Welfare Law News*, April 2002, www.welfarelaw.org/immigrant/access.htm.

[50] The New York *Growing Up Healthy* application can be found at http://www.health.state.ny.us/nysdoh/chplus/growing_up_healthy_application.htm.

VI. IMPROVING ACCESS TO HEALTH CARE SERVICES FOR IMMIGRANTS

Various factors can limit access to care and quality of care for persons with health coverage. As with the barriers to enrollment discussed above, some of these factors affect both immigrants and U.S. citizens. Such factors include the absence of nearby health care facilities, inadequate numbers of primary care physicians and specialists in some areas, the accessibility of facilities and services to persons with disabilities, and lack of transportation or child care. [51]

Other factors have a disproportionate impact on immigrants' access to health care services. The most significant of these factors are language barriers that impede access to health care or diminish the quality of medical care.[52] Language barriers also may impede access for some U.S. citizens, including some immigrants who have become U.S. citizens, some U.S.-born children of immigrants, and some U.S. citizens who were born or reside in U.S. territories such as Puerto Rico. Another issue involves access to emergency services, particularly for immigrants who are ineligible for Medicaid. Although all immigrants who meet Medicaid's financial and categorical eligibility requirements can receive Emergency Medicaid regardless of their immigration status, immigrants often do not know that they may be eligible for Emergency Medicaid.

A. Reducing Language Barriers

Numerous studies report that language barriers can impede access to health coverage and diminish access to and the quality of medical care. For example:

- In focus groups conducted in eight cities, low- and moderate-income Hispanic workers stated that language barriers kept them from learning about options for health coverage and also from obtaining needed health services if they had coverage.[53]
- Hispanics who speak Spanish as their primary language at home report more problems communicating with their doctor than Hispanics whose primary language is English. Some 43 percent of Spanish-speaking Hispanics had communication problems with their doctor, compared to 26 percent of English-speaking Hispanics and 16 percent of whites. Also, non-English speakers had more difficulty understanding instructions from the doctor's office.[54]

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[51] For more information on some of these barriers to access, see "Access to Health Care: Sources and Barriers 1996," Agency for Health Care Policy and Research (1997). Among other things, this report finds that 14 percent of insured persons under age 65 did not have a "usual source of care" in 1996. Research has shown that persons with a usual source of care are more likely to receive preventive health care services and certain treatments.

[52] A related issue, the "cultural competence" of providers, may affect immigrants' (and members of minority groups) access to quality to health care. An HHS report describes cultural competence as "being able to recognize and respond to health-related beliefs and cultural values. "National Standards for Culturally and Linguistically Appropriate Services in Health Care: Executive Summary," Office of Minority Health, pg. 5 (March 2001).

[53] Michael Perry and Susan Kannel, "Barriers to Health Coverage for Hispanic Workers: Focus Group Findings" (New York: Commonwealth Fund, December 2000).

[54] Karen Scott Collins and others, "Diverse Communities, Common Concerns: Assessing Health Care Quality for Minority Americans" (New York: Commonwealth Fund, March 2002).

- "Ad hoc" interpreters — such as family members or friends — are much more likely than professional interpreters to make mistakes in interpreting medical information that are likely to have adverse health consequences.[55]

As noted, language barriers can prevent immigrants from enrolling in and maintaining coverage. Language barriers also can make it difficult or impossible for immigrants to make full use of the health services that are available to them. Patients may be unable to give medical staff a complete and accurate medical history, for example, and staff may be unable to explain test results or provide information on how to take medications. A detailed discussion of effective responses to language barrier problems—particularly those in clinics, hospitals and other medical settings—is beyond the scope of this report. (Several other resources are available that provide such a discussion.)[56] However, it should be noted that health care providers that receive Medicaid or SCHIP payments, or other federal financial assistance, are subject to the Title VI requirements discussed earlier and, as such, must ensure that LEP patients have meaningful access to their services.

B. Improving Access to Emergency Room Services

Immigrants often do not know that they are eligible for Emergency Medicaid. As a result, they may avoid or delay seeking treatment for an emergency medical condition, or may believe that they have to pay for the treatment they receive. Community education efforts—targeted not only to immigrants, but also to service providers and hospitals—can help ensure that immigrants do not avoid obtaining emergency medical treatment because of concerns about cost or other factors. Several organizations have produced community education materials on Emergency Medicaid. For example, the Northwest Justice Project in Washington State developed a two-page fact sheet that explains the eligibility rules for Emergency Medicaid and lists the types of medical conditions that are covered.[57]

States can increase access to emergency care by enrolling immigrants in the Emergency Medicaid program before an emergency occurs, just as they enroll individuals in regular Medicaid. If a state implements such a policy, immigrants who are ineligible for regular Medicaid can apply for Emergency Medicaid at the eligibility office and receive Medicaid cards that indicate they are only eligible for emergency services. Research suggests that such "pre-emergency" enrollment procedures can increase emergency coverage while reducing the per-person costs of such coverage.[58]

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[55] Glenn Flores and others, "Errors in Medical Interpretation and their Potential Clinical Consequences in Pediatric Encounters," *Pediatrics* 111(1): 6, January 2003.
[56] See, e.g., Mara Youdelman and Jane Perkins, "Providing Language Interpretation Services in Health Care Settings: Examples from the Field," National Health Law Program for the Commonwealth Fund, May 2002 and National Health Law Program, "Medicaid/SCHIP Reimbursement Models for Language Services," National Health Law Program, February 2003.
[57] Fact sheet on Emergency Medicaid, Northwest Justice Project, Washington State, www.nwjustice.org/docs/8144.html.
[58] See Leighton Ku and Bethany Kessler, "The Number and Cost of Immigrants on Medicaid: National and State Estimates" (Washington, DC: The Urban Institute, December 16, 1997).

VII. CONCLUSION

Lack of health insurance coverage remains a significant challenge faced by immigrants in the United States. The number of legal immigrants receiving Medicaid and SCHIP has decreased considerably over the past several years, due in large part to eligibility restrictions imposed on immigrants by the 1996 welfare law. This has contributed to marked disparities in the level of health coverage between low-income U.S. citizens and immigrants.

States have several options to help increase coverage and access to care among immigrants. As of 2004, 23 states have used their own funds to provide coverage for some or all immigrants who are subject to the federal Medicaid and SCHIP eligibility restrictions and seven states utilized the SCHIP option of providing prenatal care regardless of immigration status. Nearly all of these states provided coverage to legal immigrants who are children or pregnant, and most of these states provided coverage to disabled and elderly adults as well as parents. A number of the states provide coverage that is equivalent to Medicaid and SCHIP coverage while others provide more limited coverage. For example, some state-funded coverage programs for immigrants have enrollment caps, premiums, limited benefits, and/or cost sharing not found in Medicaid.

States also can undertake efforts to encourage enrollment of immigrants who remain eligible for Medicaid and SCHIP. For example, a number of states have taken steps to reduce language barriers, to educate immigrants that enrollment in Medicaid and SCHIP does not negatively affect their immigration status, and to reduce unnecessary requests for information, such as social security numbers for family members who are not applying for benefits. Additionally, there are a number of actions that states can take to promote access to care among immigrants, including assuring that health care providers provide appropriate assistance to individuals with limited English proficiency and educating immigrants about availability of Emergency Medicaid.

Analysis suggests that these state-funded coverage programs for immigrants and other state efforts have been effective in reducing uninsured rates among immigrants. Noncitizen children living in states with state-funded programs have lower uninsured rates than such children living in states without such programs. It seems likely that the difference is due not only to the state-funded programs but also to more successful efforts to enroll noncitizens who are eligible for Medicaid and SCHIP.

In conclusion, the limits placed on Medicaid and SCHIP eligibility for immigrants in 1996 appear to have had a significant impact, contributing to high uninsured rates among immigrants, increasing disparities in coverage between immigrants and native citizens, and increasing disparities in coverage of immigrants living in different states. State efforts to provide replacement coverage programs for immigrants who are ineligible for Medicaid and SCHIP and to encourage enrollment and access to care among eligible immigrants have been successful in helping to stem the impact of the eligibility restrictions. However, immigrants continue to face disproportionate challenges to accessing coverage and care.

Appendix A

Table 1:
Children's Income Eligibility Guidelines for State-Funded Immigrant Health Coverage, 2004
(as a Percent of the Federal Poverty Level)

	Medicaid Replacement Program			SCHIP Replacement Program	Other Coverage
	Infants (0-1)	Children (1-5)	Children (6-19)		
CA	200	133	100	250	
CT	185	185	185	300	
DE	200	133	100	None	
DC	200	200	200	None	200
FL		None		200	
HI	200	200	200	N/A	
IL	200	133	133	185	
ME	200	150	150	200	
MD	200	200	200	300	
MA	200	150	150	200	400+
MN	280	275	275	N/A	
NE	185	185	185	N/A	
NJ	350	350	350	350	
NM	235	235	235	NA	
NY	200	133	133	250	
PA	185	133	100	200	235
RI	250	250	250	N/A	
TX		None		200	
VA	133	133	133	None	
WA		None		None	200
WY	133	133	100		

NOTES:

Replacement program income eligibility guidelines are the same as those used in states' federally-funded Medicaid and SCHIP programs unless noted.

N/A: State uses SCHIP dollars to expand Medicaid and does not have a separate SCHIP program.

Massachusetts and Pennsylvania also provide coverage to children with incomes above SCHIP levels (eligibility shown in other coverage).

Appendix A

Table 2:
Parents' Income Eligibility Guidelines for State-Funded Immigrant Health Coverage, 2004

	Income Thresholds for Medicaid Replacement Coverage (Based on a Family of Three as of April 2003)						Other Coverage (as a Percent of Poverty)
	Thresholds for Unemployed			Thresholds for Employed			
	Monthly	Annual	Percent of Poverty	Monthly	Annual	Percent of Poverty	
CA	$1,272	$15,260	100%	$1,362	$16,340	107%	
CT	$1,272	$15,260	100%	$1,362	$16,340	107%	
DE	$1,272	$15,260	100%	$1,528	$18,334	120%	
DC		NONE			NONE		200%
IL	$623	$7,476	49%	$1,054	$12,648	83%	
ME	$1,908	$22,890	150%	$1,998	$23,970	157%	
MN	$3,498	$41,976	275%	$3,498	$41,976	275%	
NE	$626	$7,512	49%	$726	$8,712	57%	
NY	$1,908	$22,890	150%	$1,908	$22,890	150%	
PA	$421	$5,052	33%	$842	$10,104	66%	200%
RI	$2,353	$28,231	185%	$2,443	$29,311	192%	
WA		NONE			NONE		200%
WY	$590	$7,080	46%	$790	$9,480	62%	

Notes:

Replacement program income eligibility guidelines are the same as those used in states' federally-funded Medicaid programs unless noted.

These tables take earnings disregards into account when determining income thresholds for working parents. In some cases, these disregards may be limited to a certain number of months. States also may use additional disregards in determining eligibility. Finally, in some states all or part of the income of a noncitizen's sponsor may be included in determing whether the noncitizen meets the income test for these programs.

Enrollment in Pennsylvania's and Washington's "other coverage" programs was closed as of early 2004.

Appendix B
Table 2 Notes

Most states with state-funded programs provide coverage both to “qualified” immigrants — as that term is defined in the federal welfare law: lawful permanent residents (including Amerasians); refugees, asylees, persons granted withholding of deportation; persons paroled into the United States for at least one year; persons granted conditional entry; certain battered spouses and children; Cuban/Haitian entrants, and certain victims of trafficking — and to certain other lawfully residing immigrants who are not included in the qualified-immigrant category. States use various terms to describe the category of immigrants who are eligible for state-funded coverage even though they are not qualified immigrants, including “lawfully residing” immigrants, “lawfully present” immigrants, and “persons who are permanently residing under color of law” or “PRUCOL” immigrants. When a state provides coverage to non-qualified immigrants, that fact is noted using the term the state uses to describe the category of non-qualified immigrants that it covers.

The information in this table is based heavily on initial survey work completed by the National Immigration Law Center (NILC). We are grateful to NILC, especially Tanya Broder and Tyler Moran, for their valuable research and assistance on this project. The final version of this chart is based on a survey of state officials conducted by CBPP that was completed in May 2004. This chart also reflects decisions that four states— Arkansas, Connecticut, Hawaii, and Massachusetts — made during their 2004 legislative sessions and were effective in July 2004.

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