

Health Care Access for Children in Immigrant Families: A Primer for State Legislators

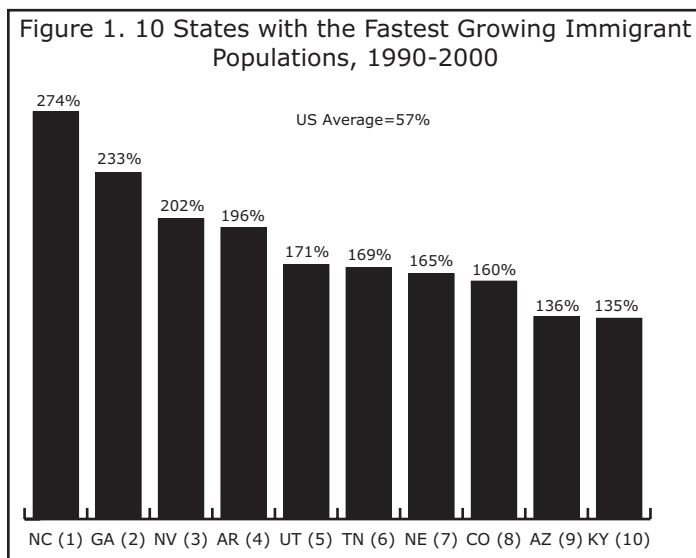
By Kelly Wilkicki and Anna Spencer

Children from immigrant families are more likely than their U.S. counterparts to be uninsured. Although legal and illegal immigrant children comprise only 4 percent of the country's 78 million children, they constitute a disproportionate share of the uninsured.¹ In 2005, 45 percent of low-income immigrant children were uninsured, compared with 17 percent of all low-income citizen children.²

This primer offers an introduction to health care access for children in immigrant families in the United States, including eligibility requirements for Medicaid and SCHIP, enrollment barriers to public programs, and examples of state efforts to improve coverage.

DEMOGRAPHICS

Once the concern of a few states, immigration issues have grown in importance as total immigration has increased and dispersion patterns have changed (Figure 1). In 2005, there were 35.2 million



Source: Randy Capps, *The Demography of U.S. Children of Immigrants* (Nashville, Tenn.: Annie E. Casey Foundation, National Family to Family Conference, May 2006), <http://www.f2f.ca.gov/res/1>, accessed 5 May 2006.

immigrants living in the United States, or 12.4 percent of the U.S. population.³ (Figure 2). Although over half of all immigrant children (authorized and otherwise) live in California, Florida, New York and Texas, the dispersion of immigrants is changing. The states experiencing the highest rate of growth of immigrants are areas that historically had very few immigrants, such as Georgia, North Carolina and Arkansas.

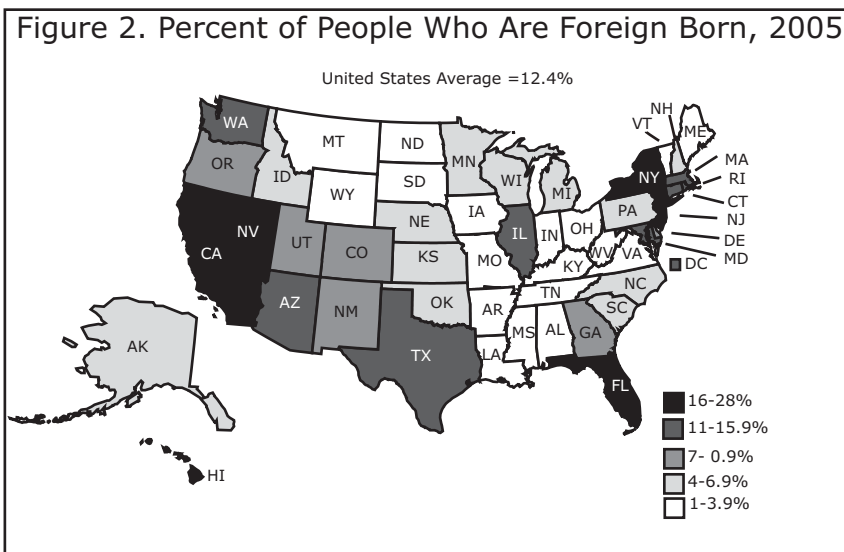
During the past decade, health insurance coverage among legal immigrants has declined as a result of the welfare reform laws passed in 1996 that bar most immigrants from receiving public benefits for five years after they enter the country.

Today, almost half of all legal immigrant children are without health coverage, yet 75 percent of children under six in immigrant families are U.S. citizens and potentially eligible for Medicaid or the State Children's Health Insurance Program

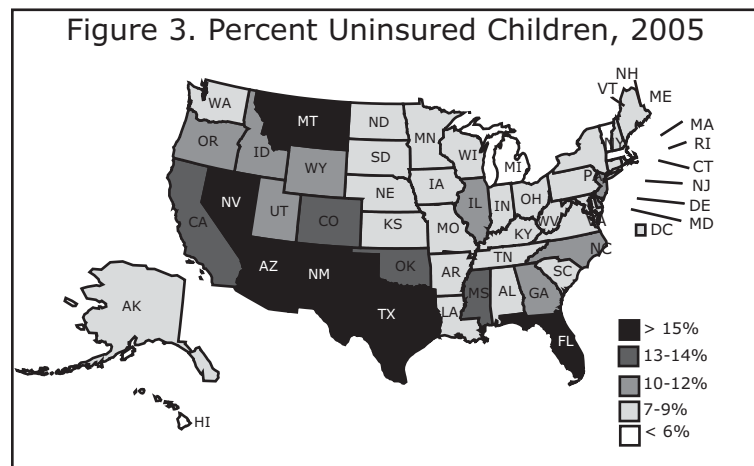
(93 percent of uninsured legal immigrant children are eligible for health coverage). Non-citizen children are three times as likely to be uninsured than children with native born parents (45 percent compared to 15 percent), and citizen children with non-citizen parents are almost twice as likely to lack health coverage compared to citizen children with native born parents.

In addition to the rules imposed by the 1996 welfare reform law that bar immigrants from participating in publicly funded health insurance programs for 5 years, legal immigrants are less likely to have employer-sponsored health insurance than are native citizens (one-third versus two-thirds),⁴ in part because a disproportionate share of immigrants work in low-wage jobs, at small firms and in labor, service or trade occupations that are less likely to offer health benefits. Language barriers, confusion about the health system and fear of reprisals from immigration officials also contribute to low rates of health insurance coverage among immigrants.

Access to health care coverage significantly affects the health status of children from low-income families. Medicaid- and SCHIP-enrolled children are more likely to report that they have a usual source of care than are their uninsured counterparts, are far less likely to have unmet health care needs, and are more likely to have well-child and regular dental and vision care. Ensuring access to regular care offers benefits to the community and overall public health. For example, uninsured children are 24 percent less likely to receive all the recommended vaccinations that protect the public's health than are the insured, according to the Centers for Disease Control and Prevention (see Figure 3 for state-level uninsurance rates for children).⁵



Source: "United States -- States; and Puerto Rico; Percent of People Who are Foreign Born: 2005" Geographic Comparison Table. 2005. (U.S. Census Bureau, 2005). <http://factfinder.census.gov/>, accessed 11 May 2007.



Source: Kaiser Family Foundation. A Decade of SCHIP Experience and Issues for Reauthorization, 2007.

Healthy children also are more likely to succeed at school. Data from the National Health Interview Survey indicates that children without health insurance are 25 percent more likely to miss school and have poorer academic performance than their insured counterparts.⁶

Receiving appropriate and timely preventive care also is cost saving. Children with a regular source of health coverage are less likely to use

the emergency department for preventable conditions such as asthma. Avoiding unnecessary emergency care saves federal, state and local taxpayers millions of dollars each year. It is estimated that uncompensated emergency department care cost \$34.6 billion in 2004.

FEDERAL FRAMEWORK FOR COVERAGE OF CHILDREN IN IMMIGRANT FAMILIES

Medicaid and the State Children's Health Insurance Program (SCHIP)

Established by Congress in 1965, Medicaid is the nation's largest publicly funded health financing program for low-income people. Financing for Medicaid is shared by the federal government and states. The size of the federal match for state dollars is based on states' relative per capita income. In 2007, Medicaid covered 55 million people, including 28 million children.

To qualify for Medicaid, an individual must meet financial criteria and fall into a category that is eligible for the program, including children, parents of dependent children, pregnant women, people with disabilities and the elderly. Federal law sets the minimum requirements for eligibility and benefits, but states have broad optional authority to extend Medicaid beyond these minimum standards. Thus, Medicaid eligibility and coverage differ from state to state. The federal share of a state's Medicaid spending is called the federal medical assistance percentage (FMAP). The FMAP formula is based on average per capita income; states with per capita incomes above the national average receive lower matching percentages while states with per capita incomes below the national average receive a higher match rate. By law, the minimum FMAP is set at 50 percent, and the maximum is set at 83 percent.

The [State Children's Health Insurance Program \(SCHIP\)](#) was created as part of the [Balanced Budget Act of 1997 \(BBA\)](#). SCHIP provides health insurance coverage to 6 million low-income children under age 19 who are not eligible for Medicaid. In the BBA, Congress allocated more than \$40 billion for the program through 2007, making it the largest federal expansion of health insurance coverage since the passage of Medicaid. Presently, one in four low-income children receives health coverage via Medicaid or SCHIP.⁷

A capped entitlement to the states, SCHIP receives a higher federal match rate than Medicaid. States may choose to administer SCHIP as an expansion of the state Medicaid program, as a stand-alone insurance program or as a combination of these approaches. Eighteen states operate separate SCHIP programs, 11 states and the District of Columbia implemented SCHIP by expanding Medicaid and 21 states use a combination approach. States that implement SCHIP through Medicaid expansions receive federal funding at the lower Medicaid matching rate if they exceed their federal SCHIP allotment.

Although Medicaid and SCHIP have certain required benefits and eligibility categories, states have many options to adapt the program to fit state preferences. Within boundaries defined by the federal government, for example, states can set income eligibility levels, include optional services or require cost sharing. To further increase program flexibility, states may seek a [waiver](#) from the Department of Health and Human Services. The [Centers for Medicare and Medicaid Services \(CMS\)](#) within the [Department of Health and Human Services \(DHHS\)](#) has federal oversight authority for Medicaid and SCHIP.

Welfare Reform

The 1996 [Personal Responsibility and Work Opportunity Reconciliation Act \(PRWORA\)](#), commonly referred to as the welfare reform law, established new restrictions on eligibility of legal immigrants for federally funded public benefit programs (TANF, Food stamps, SSI, Medicaid and SCHIP). The welfare law distinguishes between “qualified” immigrants (legal permanent residents, refugees and certain other immigrant groups) and “not qualified” immigrants (illegal and temporary immigrant residents). The terms “qualified” and “not qualified” do not indicate eligibility for public benefits. Eligibility depends upon when the immigrant arrived in the United States (before or after enactment on Aug. 22, 1996), whether he or she has met the 40-quarter work requirement, and whether he or she meets the program eligibility requirements such as income or asset limits.

In general, legal immigrants who arrive in the United States after Aug. 22, 1996, must wait five years before they can receive Medicaid or SCHIP benefits. Deeming, which is the inclusion of an immigrant’s sponsor’s income and assets in determining eligibility, applies until citizenship is attained or 40 work quarters are achieved.

Immigrant categories subject to the five-year bar include lawful permanent residents, battered spouses and children, and immigrants granted humanitarian parole for at least one year. These immigrants, or “parolees,” do not meet visa requirements but are permitted to enter the country for humanitarian purposes.

Immigrant categories that are not held to the five-year bar include refugees and other humanitarian immigrants, Cuban-Haitian entrants, victims of a severe form of trafficking, certain abused spouses and children, conditional entrants (prior to April 1, 1980), Amerasians, veterans, active-duty military personnel and their families, and immigrants whose deportations are being withheld. Elderly and disabled immigrants who qualify for Supplemental Security Income (SSI) are automatically eligible for Medicaid and therefore are exempt from the five-year bar.

Most classes of immigrant children who meet income eligibility limits must wait five years to receive benefits. Immigrants who were residing in the United States before Aug. 22 1996, are eligible for SCHIP and, at state option, for Medicaid (with states receiving the federal match). All states except Wyoming provide Medicaid to pre-enactment-qualified immigrants.

For children who are lawful permanent residents, the quarters worked by parents count toward their quota. Federal law mandates that separate, stand-alone SCHIP programs cannot impose any additional eligibility restrictions; therefore, after the five-year bar, qualified immigrant children are eligible. Some states also cover otherwise eligible children but for the 5-year bar.

“Not qualified” immigrants are not eligible for Medicaid, although states may spend their own funds to cover them without a federal match. States may cover unauthorized immigrants, also known as illegal or undocumented immigrants; non-immigrants, including temporary workers, students and travelers; those granted humanitarian parole for less than one year; asylum applicants; and other classes of immigrants who have been granted temporary permission to remain in the United States.

Federal law requires that both legal and unauthorized immigrants who meet all Medicaid eligibility requirements can receive emergency Medicaid. This category covers only treatment for medical emergencies, not preventive or routine services. Under federal law, hospitals are required to screen

and stabilize all individuals who seek care in their emergency departments.

Deficit Reduction Act (DRA)

Under the [Deficit Reduction Act](#) (DRA) of 2005, individuals who apply for or renew coverage in Medicaid or SCHIP must provide proof of citizenship and identity. Although the intent of the DRA was to guide Medicaid policy only, it also influences those SCHIP programs that are administered as Medicaid expansions. Previously, participants were allowed to attest to their citizenship under penalty of perjury; evidence was required if the statements were questionable. Applicants also are required to provide written proof of their residency status (Table 1).

Table 1. Examples of Citizenship and Identity Documents

- A valid U.S. Passport
- A U.S. birth certificate
- Certificate of citizenship
- Certificate of naturalization
- A state-issued drivers license (only if the state requires proof of citizenship and verifies social security numbers)
- Birth report of delivery abroad of a U.S. citizen
- Government issued ID, federal state or tribal census data, school ID with photo.

The eligibility rules for immigrants did not change under the DRA. Immigrants must continue to provide proof of immigration status to obtain Medicaid or SCHIP.

BARRIERS TO HEALTH CARE COVERAGE

Approximately 75 percent of uninsured children are eligible for Medicaid or SCHIP, 11 percent of whom are immigrants.⁸ Reasons for low participation in public programs by immigrants include restrictions imposed by the PRWORA and the DRA, language barriers, lack of parental knowledge about benefit programs, cost sharing and state-imposed enrollment caps.

PRWORA and DRA.

The five-year ban on eligibility for Medicaid and SCHIP is an obvious barrier for new immigrants to enrollment in public health programs. The citizenship and identity requirements set forth in the DRA also pose challenges for immigrants and citizens who enroll in Medicaid and SCHIP. Following implementation of the DRA, states began reporting declines in enrollment and application backlogs; up to 6.7 percent of beneficiaries lost coverage for some period of time in 2007.⁹ In addition, 90 percent of health centers reported difficulty with the new enrollment stipulations, and more than one-third of these centers increased staff time to help beneficiaries meet the requirements.¹⁰

Groups that are particularly likely to have problems obtaining citizenship and identity documents are Native Americans; people with disabilities who do not receive Medicare, SSI or SSDI; the homeless; and people who are forced to relocate due to natural disasters (for example, Hurricane Katrina victims). [The Tax Relief and Health Care Act of 2006](#) (TRHCA) exempted children in foster care and people who receive Medicare, SSI and SSDI benefits from the DRA proof of

citizenship and identity requirements. When acceptable forms of citizenship documentation cannot be secured, a sworn affidavit is allowed.

Parental Knowledge and Language Barriers.

Parents may be misinformed about Medicaid/SCHIP, eligibility criteria or the required application materials. Citizen children living in families that include non-citizen parents, siblings, extended family or housemates are particularly at risk of not receiving benefits, even though they are eligible.

In addition, many parents may fear that applying for coverage for their children could potentially affect their immigration status. Unauthorized immigrants may fear that enrolling their citizen children in Medicaid/SCHIP will result in their own deportation, while legal immigrants often fear being classified as a “public charge,” or dependent on government assistance. If deemed a public charge, the immigrant is prevented from becoming a U.S. citizen or from sponsoring a family member in the future. This outcome is highly unlikely for children, since only long-term institutional care—a service rarely used by children—can subject applicants to that risk.

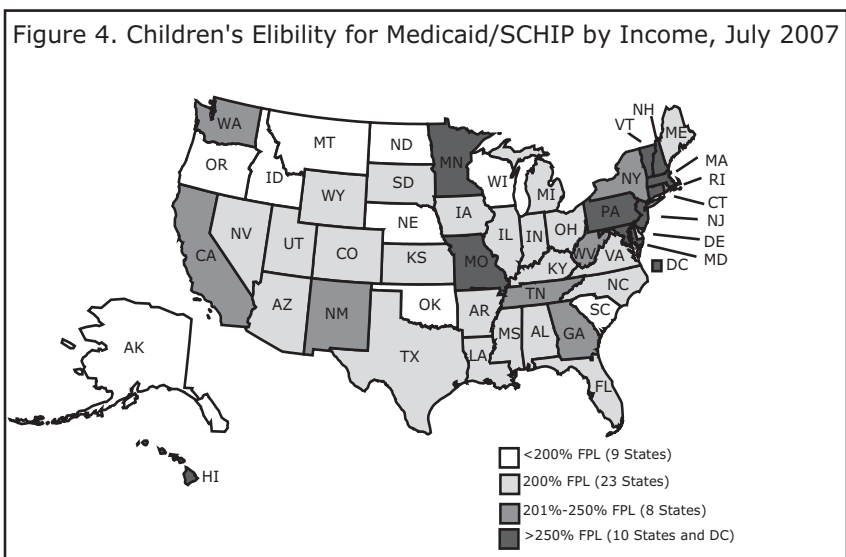
Federal law clearly states that receiving medical assistance does not constitute public charge. Even so, some states have issued policy statements reiterating that Medicaid or SCHIP enrollment does not constitute becoming a public charge, and that family members who are not applying for benefits do not have to provide Social Security numbers. Iowa, Idaho, New York and Texas include information on their Medicaid applications indicating that receipt of benefits will not affect immigration status.

Immigrants who have limited ability to read, speak or understand English have difficulty learning about the availability of health coverage programs, completing applications and re-determination processes, and obtaining services once enrolled. Under Title VI of the 1964 Civil Rights Law, Prohibition Against National Origin Discrimination Affecting Limited English Proficient (LEP) People, recipients of federal financial assistance are required to take reasonable steps to ensure meaningful access to their programs and activities by LEP persons. States provide translation and interpretation services, and many Medicaid programs offering program enrollment forms in several languages. Minnesota, for example, offers medical assistance applications in 11 languages.¹¹

Eligibility Requirements.

As of July 2007, 41 states and the District of Columbia set income eligibility levels for SCHIP at or above 200 percent of the FPL.¹²

In August 2007, CMS issued new rules that impose additional enrollment restrictions for SCHIP. Under the rule, states that wish to expand SCHIP coverage above 250 percent of the FPL must already have enrolled in SCHIP at least 95



Source: Kaiser Family Foundation. Health Coverage of Children: The Role of Medicaid and SCHIP, 2007.

percent of children in families with incomes below 200 percent of the FPL. In addition, states must implement strategies to protect against “crowd out,” including extending wait periods for enrollment to one year if a child has previously held private coverage and imposing cost sharing schemes similar to local private plans.

As of December 2007, 23 states had passed legislation to expand coverage to children above 250 percent of FPL. Several states—Arizona, Maryland, New York, Washington—filed a lawsuit in October 2007 challenging the CMS directive. Illinois, California, Connecticut, New Hampshire and New Mexico filed papers in support of this action. New Jersey issued a similar but separate lawsuit against the federal government (Figure 4).

Cost Sharing and Enrollment Caps.

Research shows that cost sharing creates a barrier to obtaining and maintaining coverage, reduces the use of necessary services and increases the financial strain on families who already spend a substantial amount of their income on medical expenses.

Medicaid permits cost-sharing on a limited basis. Monthly premiums are not allowed in Medicaid for “mandatory” children (≤ 133 percent of the federal poverty level (FPL) for children under age 6 and ≤ 100 percent of the FPL for children ages 6 to 17) and “state-optional” children (≥ 133 percent of the FPL for children under age six and ≥ 100 percent of the FPL for children ages 6 to 17). Cost sharing, in the form of deductibles and copayments, is permitted in certain circumstances. Cost sharing is not permitted for preventive care.

The rules for cost sharing in the SCHIP program and for higher income Medicaid families are broader. For families with incomes between 100 percent and 150 percent of the FPL (\$17,170 to \$25,755 for a family of three), states may charge limited premiums and can charge up to \$5 per appointment for medical visits, with total out-of-pocket expenditures not to exceed 5 percent of the family’s annual income. Families that earn above 150 percent of the FPL may be asked to pay some premiums, deductibles and copayments so long as the total cost sharing does not exceed 5 percent of the family’s annual income. As of July 2006, 35 states charged premiums or enrollment fees in their SCHIP programs, while 22 states charged copayments for services.¹³

Some states have instituted enrollment caps and enrollment freezes to curb uptake and further contain program costs. In these states, even if applicants meet all requirements, timing of the application determines whether the applicant will receive benefits. An enrollment cap allows a state to establish a certain number of eligibility slots for children; as some leave the program, others are allowed to enter. An enrollment freeze, on the other hand, prevents new applicants from enrolling until after a certain date.

STATE EFFORTS

In 2004, 23 states used their own funds to provide coverage to legal immigrants who were ineligible for Medicaid or SCHIP due to the PRWORA-imposed restrictions.¹⁴ Twenty-five states provide SCHIP prenatal care regardless of the mother’s immigration status.¹⁵ Through state-level SCHIP waivers, eight states use SCHIP funds to cover parents, four cover childless adults and 11 cover pregnant women.¹⁶ As of May 2007, Illinois, Maine, Massachusetts, Pennsylvania, Vermont and

Washington had enacted plans to provide insurance to all children, including, in some cases, unauthorized immigrant children.¹⁷

(For a list of state-funded programs that provide health coverage to immigrants who are not eligible for Medicaid, visit http://www.nilc.org/pubs/guideupdates/tbl10_state-med-asst_2007-07_2008-03.pdf)

Other efforts to increase enrollment and maintain coverage in Medicaid and SCHIP for eligible children include elimination of asset tests in 46 states and face-to-face interviews in 48 states, reduction of verification requirements through presumptive eligibility (nine states), and adoption of 12-month continuous eligibility (16 states).¹⁸

Some states have created innovative outreach programs to target hard-to-reach populations, using print, radio and television media formats, in both the mainstream and ethnic outlets. States have partnered with schools, community-based organizations, public agencies and health care providers to boost coverage among those eligible but not enrolled. For example, Illinois sent school children home with brochures and magnets advertising the “All Kids” program, and has employed “application agents” who receive \$50 per child successfully enrolled. Pennsylvania established a statewide toll-free number to provide information about SCHIP, while Florida developed separate marketing materials for racial and ethnic minority groups.

FEDERAL OUTLOOK

Congressional action has stalled in both the SCHIP and immigration arenas. FY 2007 marked the final year of SCHIP’s original 10-year authorization. After two presidential vetoes, Congress failed to pass legislation reauthorizing the program. On Dec. 29, 2007, President Bush signed a continuing resolution—[The Medicare, Medicaid and SCHIP Extension Act of 2007](#)—that provides money to states to fund their SCHIP programs through March 31, 2009. However, in the absence of federal legislation, many states are reluctant to increase outreach efforts to enroll more children in their Medicaid and SCHIP programs.

Since 1996, legal immigrant children have been barred from SCHIP and Medicaid for their first five years in the United States. Congress has introduced legislation to reverse the bar and provide states with the option to cover otherwise eligible low-income legal immigrant children and pregnant women. In another effort, federal immigration reform bills in both 2006 and 2007 would have provided grants to states to assist with health services for immigrants. These efforts have been unsuccessful due to gridlock on comprehensive immigration reform. The next potential for immigrant-related legislation is likely to occur in the summer of 2009.

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