Center on Budget and Policy Priorities

820 First Street NE, Suite 510
Washington, DC 20002

Tel: 202-408-1080
Fax: 202-408-1056

center@cbpp.org
www.cbpp.org

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REDUCING DISPARITIES IN HEALTH COVERAGE FOR LEGAL IMMIGRANT CHILDREN AND PREGNANT WOMEN

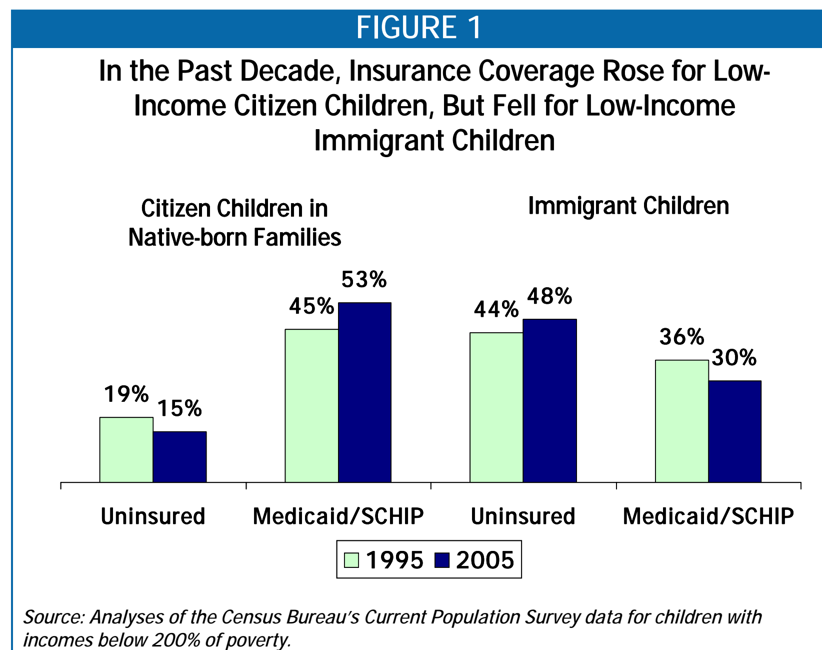
by Leighton Ku

A key health policy success of the past decade is the substantial reduction in the number of uninsured children, primarily due to improvements in Medicaid and the creation of the State Children's Health Insurance Program (SCHIP).[1] However, while there are fewer uninsured *citizen* children, the percentage of low-income *immigrant* children who lack health coverage has climbed since 1996, when federal legislation restricted the eligibility of legal immigrants for Medicaid and SCHIP during their first five years in the United States (Figure 1). The disparities in health insurance coverage between citizen and immigrant children, already large a decade ago, have grown significantly larger. Today, almost half of low-income immigrant children are uninsured.

The widening gaps in health coverage have made it harder for immigrant children to secure medical care and have jeopardized their health. These problems are compounded by other hardships, such as food insecurity, that children in immigrant families often face.

FIGURE 1

In the Past Decade, Insurance Coverage Rose for Low-Income Citizen Children, But Fell for Low-Income Immigrant Children



Source: Analyses of the Census Bureau's Current Population Survey data for children with incomes below 200% of poverty.

SCHIP reauthorization, which must be completed this year, offers an opportunity to address these health insurance coverage disparities among some legal immigrants. Congress could include, as part of SCHIP reauthorization, a provision restoring to states the option to provide Medicaid and SCHIP coverage to legal immigrant children and pregnant women during their first five years in the country. Such a proposal is supported by the National Governors Association (NGA) and many other organizations. It was approved by the Senate in 2003.

[1] L. Dubay, J. Guyer, C. Mann, and M. Odeh, "Medicaid at the ten-year anniversary of SCHIP: Looking backward and moving forward." *Health Affairs,* 2007; 26(2):370-381.

Current Health Coverage of Legal Immigrants: A Patchwork System

Before 1996, legal immigrants were eligible for Medicaid coverage on the same terms as citizens; they could be covered if they otherwise met a state's Medicaid income and eligibility criteria. The 1996 welfare legislation terminated federal eligibility for regular Medicaid coverage for most legal immigrants during their first five years in the country, regardless of how poor they are or how serious their medical needs. These provisions also apply to SCHIP, which was enacted in 1997. There are exceptions for some immigrants, such as refugees and asylees, who can continue to get insurance during their first seven years in the United States. (U.S.-born children of immigrants, who constitute the great majority of children in immigrant-headed families, are citizens and remain eligible for Medicaid and SCHIP.) Those who are otherwise barred from Medicaid due to their immigration status are eligible for Medicaid coverage for emergency medical care, which includes childbirth but not prenatal care.

Although the federal government withdrew funding for Medicaid coverage for many legal immigrants, almost half the states chose to maintain coverage for legal immigrants during their first five years in the country and to provide state-funded "replacement" coverage, without federal matching funds. Table 1 (at the end of this paper) summarizes information about states that cover legal immigrant children and pregnant women using state funding, as of 2006.

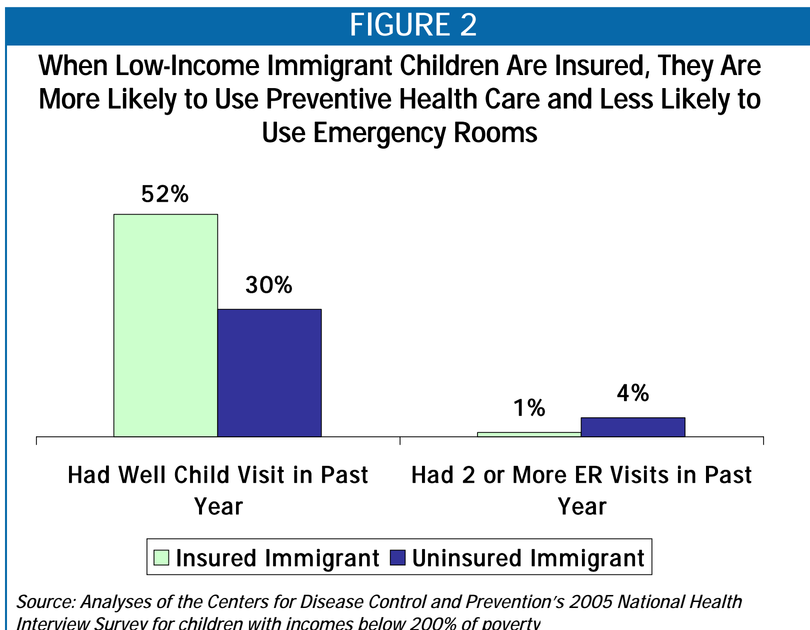
Most of the states that traditionally have high concentrations of immigrants, such as California, New York, New Jersey, Massachusetts, Texas and Illinois, are among the states that chose to continue substantial coverage for legal immigrant children and pregnant women who otherwise would be disqualified by the "five-year bar." But an important demographic shift has occurred over the past 15 years, and immigrants increasingly are located in "new growth" states like Iowa, North Carolina, Virginia, Utah or Missouri, where immigrants have found employment opportunities. The majority of these "new growth" states do *not* offer state-funded coverage for legal immigrant children and pregnant women during their first five years.

Because so many immigrant children are uninsured, they have poorer access to medical care. Research has shown that immigrant children are less likely to have a "medical home" (a usual source of health care), to see a physician, to receive dental care, or to be fully immunized than children from citizen families are.[2] (In addition, immigrants tend to rely on safety net health care providers, such as public or nonprofit health clinics and hospitals that offer uncompensated care for uninsured patients.)

Some evidence of how health insurance coverage can affect health care use for immigrant children is available from analyses of the 2005 National Health Interview Survey. Low-income immigrant children who *are* insured are more likely to receive preventive health care (well child visits) than immigrant children who are *not* insured. The insured children are *less* likely to use emergency rooms (Figure 2). (Regardless of whether they are insured or not, low-income immigrant children use emergency rooms more sparingly than low-income native-born children.)

[2] L. Ku and S. Matani. "Left out: Immigrants' access to insurance and health care." *Health Affairs* 2001; 20(1):247-56. Z.J. Huang, S. Yu, and R. Ledsky "Health status and health service access and use among children in U.S. immigrant families." *Am J Public Health*. 2006; 96(4):634-40. T.W. Strine, L.E. Barker, A.H. Mokdad, et al. "Vaccination coverage of foreign-born children 19 to 35 months of age: findings from the National Immunization Survey, 1999-2000." *Pediatrics*. 2002 Aug;110(2 Pt 1):e15.

Health insurance coverage can help immigrant children access cost-effective preventive care instead of waiting for health problems to become so severe that they necessitate more expensive emergency room care. Similarly, providing prenatal care to avoid pregnancy complications is considered more cost-effective than paying for neonatal intensive care after a child is born.



The lack of health insurance coverage is not the only barrier to health care for immigrant children. Language barriers create difficulties for immigrants who are trying to enroll in insurance coverage and, even if immigrants are insured, can create further problems when they try to locate health care providers or communicate with them. Many states have developed effective strategies to help those with limited English proficiency enroll in Medicaid and SCHIP, and a number of states also offer reimbursement for language services under Medicaid or SCHIP.[3]

Finally, children in immigrant families are subject to other hardships that may cause or exacerbate their health problems. For example, the Urban Institute found that children in immigrant families were more likely than children in native-born families to have problems affording food and to live in overcrowded housing.[4] Although Congress restored legal immigrant children's eligibility for food stamps in 1998 and 2002, some immigrant children may experience food insecurity because their families' food stamp allotments may be smaller (since their legal immigrant parents remain ineligible for food stamps) or because confusing eligibility rules deter immigrant children from participating even if they are eligible. There has been some discussion in Congress of proposals to restore food stamp benefits for other groups of legal immigrants, such as parents, when the food stamp program is reauthorized this year as part of the farm bill.

Opportunities to Restore Equity to Legal Immigrant Children and Pregnant Women

The pending SCHIP reauthorization creates an opportunity to improve health coverage for legal immigrant children and pregnant women. Bipartisan legislation that would restore states' option to provide Medicaid and SCHIP coverage to legal immigrant children and pregnant women during

[3] M. Youdelman, J. Perkins and J. Brooks, "Providing Language Services in State and Local Health-Related Benefits Offices: Examples From the Field," Commonwealth Fund, Jan. 2007. National Health Law Program, "Medicaid/SCHIP Reimbursement Models for Language Services: 2005 Update," Dec. 2005.

[4] R. Capps, M. Fix, J. Ost, et al. "The health and well-being of young children of immigrants." Washington, DC: Urban Institute, February 2005.

their first five years in the country has been introduced in the House by Representatives Lincoln Diaz-Balart (R-FL) and Henry Waxman (D-CA) (H.R. 1308) and in the Senate by Senators Hillary Clinton (D-NY) and Olympia Snowe (R-ME) (S. 764). This measure also is included in other children's health bills introduced in Congress,[5] and Senators Jay Rockefeller (D-WV) and Olympia Snowe (R-ME) have indicated that their forthcoming SCHIP reauthorization legislation will include the provision.

In states that do not currently cover legal immigrant children and pregnant women but have growing immigrant populations (such as Iowa, Utah, Kansas, Arizona or Arkansas), this proposal offers a new federal funding option that could help both legal immigrants and those health care providers who provide uncompensated care to uninsured immigrants. For states that already offer Medicaid and SCHIP coverage to legal immigrant children or pregnant women (such as California, New York, New Jersey or Oregon, see Table 1), this legislation would offer immediate fiscal assistance, by restoring the availability of federal matching funds for Medicaid or SCHIP expenditures that the states currently bear with state-only dollars. The legislation (which is known as The Legal Immigrant Children's Health Improvement Act, or ICHIA) thus would increase health insurance coverage for legal immigrant children and pregnant women, and aid states as well. Its cost would be a relatively modest $1.5 billion over five years, according to informal Congressional Budget Office estimates.

The proposal is supported by the National Governors Association,[6] the National Conference of State Legislatures, and hundreds of national and state organizations, including the American Academy of Pediatrics, the American College of Obstetrics and Gynecology, and the National Council of La Raza. The NGA has noted that the federal government sets immigration policy, and has called on the federal government to pick up its share of the costs for immigrants.

Legal immigrant families work hard and pay taxes, and most legal immigrant children will grow up to be U.S. citizens. At a time when there is much interest in further reducing the number of uninsured children and improving their access to health care, efforts to extend coverage to this small but vulnerable group of children and pregnant women strongly merit consideration.

[5] H.R. 1535 (introduced by Representative John Dingell (D-MI) and S. 895 (introduced by Senator Clinton).

[6] National Governors Association, interim policy position on SCHIP adopted by the Health and Human Services Committee on SCHIP, April 9, 2007. National Governors Association, "Immigration and Refugee Policy," March 5, 2007.

TABLE 1

States That Cover Legal Immigrant Children or Pregnant Women During the Five-Year Bar Using State-Only Funds

State	Populations Covered*
California	Legal immigrant children and pregnant women in Medicaid and SCHIP
Colorado	Legal immigrant pregnant women (prenatal care) in a state-funded program.
Connecticut	Legal immigrant children and pregnant women in Medicaid and SCHIP
Delaware	Legal immigrant children and pregnant women in Medicaid
District of Columbia	Immigrant children in limited Medicaid-like program with capped levels. Legal immigrant children and pregnant women are eligible for DC Health Alliance.
Florida	Legal immigrant children in SCHIP, but not Medicaid. Coverage is very limited because of enrollment caps established several years ago.
Hawaii	Legal immigrant children and pregnant women in Medicaid and SCHIP
Illinois	Legal immigrant children and pregnant women in Medicaid and SCHIP
Maine	Legal immigrant children and pregnant women in Medicaid and SCHIP
Maryland	Legal immigrant children and pregnant women in Medicaid and SCHIP
Massachusetts	Legal immigrant children and pregnant women in Medicaid and SCHIP
Minnesota	Legal immigrant children and pregnant women in Medicaid and SCHIP
Nebraska	Legal immigrant children and pregnant women in Medicaid and SCHIP
New Jersey	Legal immigrant children and pregnant women in Medicaid and SCHIP
New Mexico	PRUCOLs (immigrants permanently residing under color of law) who entered before August 1996 in Medicaid and SCHIP. (Very limited coverage)
New York	Legal immigrant children and pregnant women in Medicaid and SCHIP
Oklahoma	PRUCOL children in SCHIP who entered before August 1996. (Very limited coverage)
Pennsylvania	Legal immigrant children and pregnant women in Medicaid and SCHIP
Rhode Island	Legal immigrant pregnant women in Medicaid. Legal immigrant children in Medicaid and SCHIP, but the state is not enrolling additional immigrant children after December 31, 2006 unless they are enrolled in the state's welfare program.
Texas	Legal immigrant children in SCHIP, but not in Medicaid. Lower income immigrant children who would otherwise be Medicaid eligible may enroll in SCHIP.
Virginia	Legal immigrant children in Medicaid.
Washington	Legal immigrant pregnant women in Medicaid. Legal immigrant children in Medicaid up to a capped level. Legal immigrants also eligible for Basic Health, a state-funded program.

* In order to be covered, the legal immigrants must meet other Medicaid or SCHIP eligibility criteria, such as income limits. Legal immigrants applying for benefits must provide documentation of their legal status, subject to confirmation by the Department of Homeland Security.

Note: As of early 2007, several states, including Texas and Arkansas, provide coverage for prenatal care for immigrant women using federal SCHIP funds, under the SCHIP option to cover "unborn children."

Source: Center on Budget and Policy Priorities and National Immigration Law Center. Policies are as of late 2006.