Immigrant access to health care

Fewer resources, less political will to provide safety net service

By Jessie Kemmick Pintor, MPH, and Lynn A. Blewett, PhD

Immigrants and their children make up the fastest-growing group in the United States, representing 12 percent of the population in 2009. The proportion of Minnesota residents that are immigrants has increased by 38 percent over the past decade, and in 2009 the foreign-born represented 6.8 per-cent of the state's population, or 360,000 residents.

Numerous federal policies enacted over the past two decades have had a significant impact on immigrants' access to health care, and the 2010 Patient Protection and Affordable Care Act (ACA) is no exception. This article reviews the key provisions of national legislation pertaining to access to care for immigrants, highlighting the most recent provisions of the ACA.

Immigrants in Minnesota

As shown in Figure 1, Minnesota is home to immigrants from around the world. Almost one-fifth of the state's immigrants come from Mexico (17 percent), the largest single category of immigration, followed by immigrants from Europe (13 percent). Africa is also a leading source of immigration, making up 18 percent of the immigrant population in the U.S. when all African categories are combined (see sidebar.)

Legal immigrants can be in the U.S. as either naturalized citizens or legal non-citizens. Non-citizens may be here either with- or without authorization. In general, non-citizens are more likely to be from young, working families: Over two-thirds of non-citizens in the U.S. and in Minnesota are in the 18 to 44 age range; more than half of non-citizens are married; and two-thirds reside in households with children present. While most immigrants are working, non-citizens are much more likely to have incomes below the poverty level. Across the U.S. and within Minnesota, non-citizens are four times more likely to be uninsured than their citizen counterparts (U.S. Census Bureau, 2010).

Federal policies on immigrant access to coverage

Prior to 1996, legal immigrants and their children were eligible for health coverage under the Medicaid program if they met state-specific income- and asset eligibility criteria. Undocumented immigrants were not eligible for Medicaid or any other federally funded public programs, and they remain ineligible to this day. In 1996, President Clinton signed the *Illegal Immigration and Immigrant Responsibility Act and the Personal Responsibility and Work Opportunity Reconciliation Act* (PRWORA), which restructured the U.S. welfare system and had a significant impact on legal immigrants' access to federally funded programs. Under the legislation, legal immigrants lost eligibility for all means-tested, federally funded programs—including Medicaid—for the first five years they were in the U.S. After 1996, states had to proactively enact their own legislation to cover undocumented immigrants or legal immigrants subject to the five-year ban, and few states opted to do so.

Policies constructed over the next decade attempted to open up coverage for immigrant pregnant women and children. The *State Children's Health Insurance Program (CHIP) Unborn Child Amendment of 2002* provided states with the option of federal matching funds to cover care for pregnant women regardless of immigration status. Once again, however, coverage would be extended only to states proactively pursuing (and passing) legislation to cover prenatal care for these women, and care was "officially" provided or justified only for the "unborn child" whose immigration status was unknown—not the pregnant woman herself.

Legislation passed in 2009—the *Immigrant Children's Health Improvement Act*—once again gave states the option to cover "legal" immigrant pregnant women and children currently subject to the five-year ban and to receive federal financial matching payments to assist with the cost of coverage. As of January 2011, six states had opted to cover legal immigrant children, and 21 states including Minnesota covered pregnant women during the five-year waiting period.

Finally, the ACA—signed into law in March 2010—will increase access to affordable health insurance for millions of Americans, but has specifically excluded many immigrants. Improved access to affordable coverage, both public and private, will be facilitated through the implementation of federal and state health insurance exchanges; Medicaid expansions for all persons under age 65 with family incomes up to 138 percent of the federal poverty level (FPL); and an individual mandate that will require all U.S. citizens (and legal permanent residents) to purchase health insurance coverage in 2014. Despite these far-reaching coverage expansions, some 20 million people will continue to be uninsured, including a substantial proportion (about 25 percent of all uninsured adults) of the population due to their immigration status.

Under the ACA, legal immigrants are, in most circumstances, still subject to the five-year ban, and undocumented immigrants—regardless of length of time in the U.S.—will remain ineligible for public program coverage through

Medicaid or CHIP. Undocumented immigrants are also specifically prohibited from purchasing coverage in federal and state insurance exchanges, as the ACA requires that individuals purchasing exchange-based coverage meet citizenship/legal eligibility requirements. Undocumented immigrants are exempt from the individual mandate, along with a small group of individuals including, for example, American Indians and those with financial hardship or religious objections.

Significant barriers to access to care

Since 1996, significant restrictions on access to public health benefits have been placed on both legal- and non-legal immigrants. The five-year ban on access to public health insurance coverage for all immigrants that exists today results in a significant barrier to access to needed care. The ACA has not addressed the health care needs of immigrants under health reform; in fact, non-legal immigrants are specifically excluded from the individual mandate and the health insurance exchanges.

States have had some flexibility in providing coverage for excluded pregnant women under the reauthorization of the Children's Health Insurance Program, but few states have opted for this specific and targeted expansion. Several states, including Illinois, New York, and Massachusetts, have pursued state-only funded children's health insurance programs following a "Cover All Kids" strategy, with no federal financial support. The expansion of state-sponsored children's programs is highly unlikely given the downturn in the economy, state budget deficits, and the growing political divide between the two governing political parties.

So who *will* provide care to our immigrant population? Interestingly, while the U.S. explicitly restricts access to private and public health insurance coverage for immigrants, both legal and non-legal, we implicitly rely on our formal and informal safety nets to provide medical care when it is needed. Hospitals that provide services to Medicare and Medicaid patients must triage all patients and admit those who are in an emergency situation, regardless of legal status and health insurance coverage status. Those without coverage often wait until their situation has reached a crisis state before seeking care—often in the emergency room of a community hospital or at the tax-supported local public hospital whose mission is to provide care to the poor and underserved.

Community Health Centers (CHCs, also known as Federally Qualified Health Centers)—nonprofit clinics located in medically underserved areas, both urban and rural—share a mission of making comprehensive primary care accessible to anyone regardless of insurance status, immigrant status, or ability to pay. The small but growing network of 17 CHCs operating in over 70 locations in Minnesota has played an essential role in facilitating care for immigrants, providing basic primary care as legal residents wait for the five-year ban to expire and as undocumented families get their children the basic checkups and primary care services needed in the first years of life. In light of the growing restrictions under health reform, CHCs will play an even more pronounced role in covering insurance gaps among immigrants.

It's a difficult time to be talking about doing more when there is less funding at both the state and national levels, and less political will to provide the basic safety-net services to those in need. We are likely to see lower state and federal tax revenue, targeted to fewer and more narrowly defined U.S. populations.

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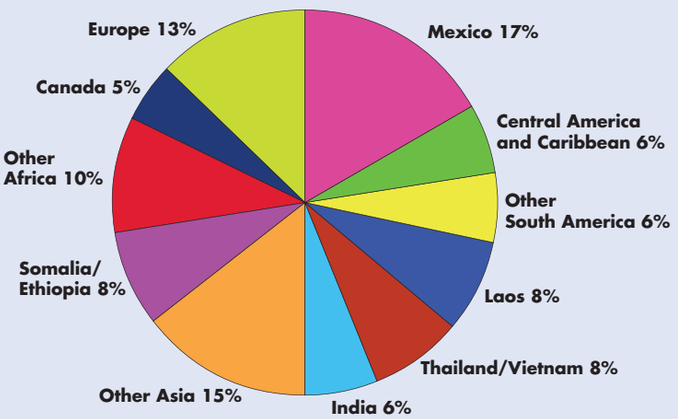
Immigrant status among non-citizens in Minnesota (2009)

"Non-citizens" include legal immigrants, non-immigrants, and undocumented immigrants.

- ***Legal immigrants*** are legal permanent residents ("green card" holders), asylees and refugees, and other immigrants with unique situations.
- ***Non-immigrants*** are individuals in the U.S. on a temporary tourist, student, or work visa.
- ***Undocumented immigrants**** are people who (1) have entered the country without approval from immigration authorities, or (2) have violated the terms of a temporary admission (e.g., overstaying a tourist/student visa without status adjustment*).

**It is estimated that of all undocumented immigrants currently in the U.S., slightly more than half entered without approval, while others have overstayed a temporary visa.*

FIGURE 1. Minnesota's immigrants.



Source: 2009 American Community Survey, U.S. Census Bureau.