# Barriers to Healthcare Access for U.S. Immigrant Children: A Policy Brief by Children's Health Fund

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## EXECUTIVE SUMMARY:

In the United States, children who recently immigrated disproportionately face barriers to healthcare and are more likely than natural-born citizens to lack access to insurance. According to the Children's Defense Fund, 25% of children in immigrant families lacked health insurance in 2019 compared to 5.1% of native-born children in families in which all members held natural-born citizenship status.

Children without insurance are more likely than children with insurance to lack a usual source of care, to delay necessary care and medical treatment, and to have unmet medical needs. Because children without documentation are disproportionately more likely than non-immigrant children to lack insurance and to not visit a physician, they experience limited access to preventive services and interrupted continuity of care.

Families with mixed immigration statuses face difficulty accessing health insurance for their children through employer-sponsored plans and those available in the marketplace. Children also face barriers to healthcare as a result of restrictive immigration policies, such as the 1999 and 2019 public charge rules, that instilled fear in immigrants seeking public benefits. While many children living in mixed-status families face barriers to healthcare, children without documentation have unique challenges. They are ineligible for Medicaid and the Children's Health Insurance Program (CHIP) in all states except those that leverage state-only Medicaid and CHIP funding to provide coverage to children without legal documentation. They are also ineligible for private insurance sold in the marketplace.

Children without documentation do have options, though limited. Currently, eight states and Washington, D.C., provide healthcare coverage for all income-eligible children regardless of immigration status. In addition, Federally Qualified Health Centers (FQHCs) provide free or low-cost care to all residents in the center's service area regardless of factors such as immigration and insurance status, and ability to pay. Children without legal documentation can access limited care through an emergency department for urgent medical conditions funded through Emergency Medicaid as long as they meet other eligibility requirements. Medicaid also provides disproportionate share hospital payments to hospitals that provide care to a large number of patients who are either enrolled in Medicaid or are uninsured, including children without legal documentation. In addition, the Emergency Medical Treatment and Active Labor Act (EMTALA), in place since 1986, requires participating hospital emergency departments to examine and stabilize anyone seeking treatment for an emergency medical condition regardless of immigration and insurance status, or ability to pay.

In order to improve healthcare access and promote health equity, policymakers should enact healthcare and immigration policies that address the needs of children, such as removing waiting periods that bar children who recently immigrated from immediately accessing Medicaid and CHIP, providing more funding for FQHCs, and using state funds to increase access to care for children without documentation in more states throughout the country.

**Background: Immigration Status as a Barrier to Healthcare**

Approximately 18 million children, or 26% of all youth under the age of 18 in the United States (2021), were either born in a foreign country or live in a mixed-status household with at least one parent who is an immigrant. Of those 18 million children, 5.3 million are estimated to either have a parent who lacks documentation or lack legal documentation themselves. Due to mandates in federal healthcare law and in immigration policy, children without legal documentation face challenges in accessing Medicaid, CHIP, and private health insurance.

*Inequities in Uninsured Rates:*

Children's Health Fund believes that all children deserve quality healthcare regardless of immigration status. Consistent care is essential to maintaining and improving the health and well-being of children. When children have regular access to comprehensive primary care, including routine well-child visits and immunizations, they are at reduced risk of severe illness and are more likely to develop into healthy adults.

Children without legal documentation disproportionately face barriers to health insurance. In 2020, 4% of all children born in the United States were uninsured but for children with at least one noncitizen parent, 10% were uninsured. That same year, the uninsured rate reached an estimated 28% for children without legal documentation.

*Ineligibility for Medicaid and CHIP:*

Medicaid is a jointly funded federal and state public health insurance program that provides comprehensive, low-cost coverage to children, elderly individuals, adults with low income, and people with disabilities. The Children's Health Insurance Program (CHIP) provides healthcare coverage for children under age 19 and pregnant individuals living in households with incomes too high to qualify for Medicaid but too low to afford private insurance.

In 2019, over 45 million children were enrolled in Medicaid and CHIP. However, a study by the Migration Policy Institute estimated that, in the same year, 2.3 million children in immigrant families met income-based eligibility requirements for Medicaid and CHIP, but about 40% were unable to enroll due to a lack of legal documentation or fewer than five years with a "qualified non-citizen" status. Qualified non-citizens are immigrants legally authorized to live in the United States including lawful permanent residents, refugees, and asylees.

In order to enroll in Medicaid and CHIP, many immigrants who classify as qualified non-citizens must reside as qualified non-citizens for at least five years before enrolling. However, since the enactment of the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA), states have had the option to remove this waiting period for children with use of federal funds. As of November 1, 2022, 34 states and Washington, D.C., have removed the five-year waiting period, allowing children with qualified status to access coverage that they are entitled to more quickly.

Still, children who lack legal documentation face even less access to Medicaid and CHIP. Federal law prohibits Medicaid and CHIP from using federal funds to provide coverage to immigrants without legal documentation. To increase access to care for immigrants who are ineligible for federally funded health

coverage, several states have chosen to use state-only funds to implement healthcare programs that provide coverage to children regardless of immigration status.

*Inability to Purchase Marketplace Insurance:*

The Affordable Care Act (ACA) sought to expand healthcare coverage to millions of people throughout the country. To improve options for the purchase of private insurance, the ACA mandated that healthcare exchanges, also known as marketplaces, be available in each state so that individuals who have no other pathway to healthcare coverage can purchase insurance. Eligible individuals include U.S. natural-born citizens and lawfully present residents.

Due to the combined effect of Medicaid expansion and ACA marketplaces, the uninsured rate among children shrunk from 7% in 2013, the year before the coverage expansions took effect, to 4% in 2016. While the national uninsured rate among children dropped by nearly 50%, children without legal documentation did not benefit from these policy changes as they remained ineligible for Medicaid, CHIP, and marketplace insurance.

*Public Charge Rule:*

The public charge rule allows the U.S. government to deny immigrants admission into the country based on their perceived use of public benefits, including Medicaid, CHIP, and food stamps. Since its enactment in 1882, the public charge rule has undergone several revisions.

Under a 1999 revision of the public charge rule, the federal Department of Homeland Security (DHS) interpreted a public charge as someone who is "primarily dependent on the government for subsistence" through use of public cash assistance for income maintenance including Temporary Assistance for Needy Families and Supplemental Security Income; or as someone who received "long-term healthcare at the U.S. government's expense," including use of Medicaid. However, this changed in 2019 when a policy change expanded the criteria for becoming a public charge. Under these expansions, immigrants could be considered public charges, not only for receiving public benefits, but also for being "more likely than not" to become dependent on government-funded public programs in the future. The 2019 version of the public charge rule created a climate of fear and confusion. Immigrant children and families worried that involvement in public programs would affect their green card application status. According to 2019 data from the Urban Institute, over 15% of adults in immigrant families reported that they or a family member avoided a government benefit program including Medicaid and CHIP "for fear of risking future green card status." Additionally, survey data from the Kaiser Family Foundation found that over 20% of health centers reported reductions in healthcare utilization among children in immigrant families.

The 2019 version of the public charge rule has since been revised. As of 2022, DHS will return to the 1999 guidance. DHS will no longer consider public charge determinations for receipt of certain non-cash benefits including the Supplemental Nutrition Assistance Program (SNAP), CHIP, Medicaid (for uses other than long-term institutionalization), and any benefits related to immunizations or testing for communicable diseases. In addition, DHS "will not consider in public charge determinations benefits received by family members other than the applicant." As the public charge rule undergoes future changes, it is important for policymakers to consider the impact of immigration policy on healthcare and health insurance access for immigrant families and children with all citizenship statuses.

**EXISTING OPTIONS: How Immigrant Children Can Access Healthcare**

Although children without legal documentation face challenges when accessing healthcare, their options for receiving care include living in a state that uses state funds to cover children regardless of immigration status, receiving care at Federally Qualified Health Centers (FQHCs), and receiving care at hospitals that are required to provide emergency examinations and treatment to all patients through the Emergency Medical Treatment and Active Labor Act (EMTALA). In addition, children can access healthcare by utilizing Emergency Medicaid, receiving care at disproportionate share payment hospitals (DSPHs), or through private health insurance.

*Use of State Funds:*

As of July 1, 2022, eight states (California, Illinois, Maine, Massachusetts, New York, Oregon, Vermont, and Washington) and Washington D.C., use state funds to provide affordable, comprehensive healthcare coverage to all children, regardless of immigration status.

Many of the state-funded healthcare programs provide services similar to those offered through Medicaid and CHIP, yet are not official Medicaid or CHIP programs. Others, such as those in California, Maine, and Vermont, operate as extensions of the Medicaid or CHIP programs.

A few other states have proposed or taken action to expand coverage for children in immigrant families. Connecticut announced that it would provide health coverage to all income-eligible children under age nine regardless of immigration status through its Medicaid program starting in January 2023, while Colorado announced that it would provide health coverage to all children under 18 without legal documentation through its Medicaid program starting in 2025. New Jersey Governor Phil Murphy proposed the "Cover All Kids Initiative" in 2021 to provide healthcare coverage to all children age 18 and under through New Jersey's program for Medicaid and CHIP, although this has not yet been enacted.

*Federally Qualified Health Centers (FQHCs):*

FQHCs can include Community Health Centers, Migrant Health Centers, Health Care for the Homeless programs, and Health Centers for Residents of Public Housing.

Over 1,400 FQHCs across the United States serve more than 30 million people annually of all ages living in under-resourced communities by providing free or low-cost healthcare regardless of insurance or immigration status. FQHCs offer a wide range of services to patients, including primary care, vision services, dental care, and behavioral health services.

While FQHCs provide a wide range of primary care services, they typically do not provide specialty or inpatient care.

*Emergency Medical Treatment and Labor Act (EMTALA):*

EMTALA is a federal law that requires physicians and medical personnel at any Medicare-participating hospital to provide a medical screening examination to any patient requesting examination or treatment for an emergency medical condition regardless of insurance status, ability to pay, or immigration status. In addition, any patient who is determined to have an emergency medical condition must be stabilized before being transferred or discharged.

Under EMTALA, an emergency medical condition is defined as any "condition requiring treatment needs to manifest itself by acute symptoms (including pain) such that absence of immediate medical attention could put the patient in serious jeopardy, seriously impair bodily functions or cause serious dysfunction to an organ or body part", such as a heart attack, a severe asthma attack, or emergency labor and delivery.

Since EMTALA prevents hospitals from denying treatment or refusing care to patients on the basis of insurance status, ability to pay, or immigration status, it allows children without legal documentation to access life-saving medical care when immediately necessary.

*Emergency Medicaid:*

While immigrant children without legal documentation are not eligible for traditional Medicaid in most states, they are eligible for Emergency Medicaid. Emergency Medicaid is a component of the Medicaid program that allows all income-eligible individuals without insurance to receive Medicaid services for the treatment of an emergency medical condition regardless of immigration status. Under Emergency Medicaid, patients can receive treatment for a maximum of 15 months.

Emergency Medicaid reduces the burden of cost for receiving care in an emergency facility, but it is temporary and limited in what can be treated since it only treats emergency medical conditions as defined under the EMTALA law.

Emergency Medicaid cannot be a source of primary and preventive care for children without legal documentation. Emergency rooms are the most expensive form of care, with estimates that receiving treatment at the emergency room can be up to 12 times more expensive than at a doctor's office. In addition, patients do not receive the continuity of care in emergency departments that they do with primary care physicians. Until all children have access to a wide range of medical services that meet their healthcare needs, children without legal documentation will be left without true access to comprehensive healthcare.

*Disproportionate Share Hospital Payments:*

Under federal law, state Medicaid programs are required to make payments, known as disproportionate share hospital payments (DSHPs), to qualifying hospitals that serve a large number of patients who are either uninsured or enrolled in Medicaid. By enabling safety net hospitals to provide care to patients who are unable to afford it, disproportionate share hospital payments widen access to healthcare for people in under-resourced communities, including children in families with mixed immigration status. Hospitals receiving DSHPs are an important source of care for children without documentation, especially in states with restrictive immigration policies and large populations of immigrants.

*Access to Private Health Insurance:*

Some immigrant families may be able to access private insurance through their employers and through non-ACA marketplaces, as there are no laws or policies that explicitly prohibit them from doing so. However, employer-sponsored insurance and private insurance purchased outside of ACA marketplaces are inaccessible for most immigrants, especially for immigrants without documentation. Many jobs require a work visa or proof of lawfully present status as a term of employment, meaning immigrants without legal documentation typically lack access to jobs that provide health insurance. In addition,

private health insurance purchased outside of ACA marketplaces is expensive and cannot be used with subsidies, making this option unaffordable to many immigrants.

## Policy Options:

In order to ensure that children in mixed-status families have access to healthcare, policymakers, legislators, advocates, and community members must work to craft immigration and healthcare policies that address healthcare access for all. These policies may include expanding Medicaid and CHIP, increasing funding for community health centers, and using state funds.

### *Medicaid and CHIP Expansion:*

Medicaid and CHIP coverage should be extended to all eligible children to ensure that they can access care when needed. Expansions in Medicaid and CHIP, through both the ACA and CHIPRA, brought affordable coverage to millions of children throughout the country, and without these efforts, children from under-resourced communities would face barriers to accessing healthcare services. However, lawfully present immigrant children are still unable to promptly access healthcare in the 16 states that require a 5-year waiting period before enrolling in Medicaid and CHIP. In order to increase access to healthcare for children with qualified immigration status, states that have not already done so should eliminate the current five-year waiting period for access to Medicaid and CHIP.

### *Increased Funding for Federally Qualified Health Centers (FQHCs):*

FQHcs receive reimbursement from Medicaid, Medicare, and private insurance. In addition, health centers are funded through federal grants that mandate all patients are seen regardless of ability to pay. As an essential part of the health and social safety net, community health centers need more funding so they can continue providing quality, comprehensive healthcare for people living below 200% of the federal poverty threshold, who lack insurance, or do not have legal documentation.

### *Use of State Funds:*

When states use their own funds to increase access to coverage for children without legal documentation, they have more flexibility to create programs that work. For example, in 2016, California initially used state funds to provide healthcare coverage to all children 18 and under regardless of immigration status. Policymakers soon realized there existed a greater need for healthcare coverage for young adults up to age 25, and amended their Medicaid program to reflect this need.

State funds should be used to provide healthcare to all immigrants, including those without legal documentation. State funds should not simultaneously increase access to healthcare for children, yet limit access to healthcare for certain categories of immigrants.

## Conclusion:

Access to healthcare coverage and services are limited for children without legal documentation.
All children need access to quality, comprehensive healthcare in order to succeed and to reach their potential in the classroom, at home, and into adulthood. Children without documentation should not be excluded from having their healthcare needs met. Policymakers and government officials must commit to creating policies that protect the health and well-being of all children.