



Health Insurance Coverage and Access to Care for Immigrants: Key Challenges and Policy Options

Many immigrants face obstacles in accessing health care services and health insurance coverage, and immigrant communities have been heavily affected by the COVID-19 pandemic. Policy changes are needed to improve health equity for this population.

KEY POINTS

- The foreign-born population in the United States is large and diverse, and health outcomes vary widely across immigrant groups. However, barriers to health care and health insurance coverage are common due to the complex nature of the health care system, policy exclusions, cultural and linguistic barriers, discrimination, mistrust, and legal concerns.
- The Affordable Care Act (ACA) and more recently the American Rescue Plan (ARP) expanded health coverage eligibility and subsidies for certain immigrant populations including naturalized citizens and lawful permanent residents. After passage of the ACA, the uninsured rate fell substantially for both children and adults in immigrant communities, with the largest change occurring among adult non-citizens who immigrated to the United States within the last 5 years (48.1 percent in 2013 to 30.6 percent in 2019). However, gaps in coverage for immigrants persist, with uninsured rates still substantially higher than those among the U.S.-born population.
- Several studies suggest that concerns over actual and perceived adverse legal consequences tied to seeking public benefits have affected whether or not immigrants seek to enroll in public programs and can lead to barriers to needed care.
- Additional actions at the national and state levels, including targeted outreach efforts, can be taken to increase health insurance coverage among eligible immigrant populations and to address challenges related to social determinants of health in order to improve health equity.

INTRODUCTION

As of 2019, approximately 44.9 million immigrants (including both naturalized citizens and noncitizens) were living in the United States (U.S.), representing 13.7 percent of the nation's population. Immigrant communities are diverse across a range of dimensions, with widely varying demographic characteristics, income, types of employment, country of origin, immigration status, and reasons for seeking residence in the U.S. Immigration status plays an important role in how immigrants interact with the health care system, as it affects what health care coverage options are available to them, and how they may be treated when obtaining care. Of particular concern are the 21.7 million non-citizen immigrants living in the U.S. who often experience lower socioeconomic status, health insurance coverage, and utilization of services, in addition to worse health

outcomes, compared to U.S. citizens.* The barriers immigrant communities experience accessing health coverage and health care, combined with the effects of social determinants of health, make this an important area for policy attention to improve health equity. This paper describes some of these key disparities, analyzes trends in health insurance coverage among immigrants over the past decade, and identifies potential policy interventions to address gaps in health care access and social determinants of health for members of foreign-born and immigrant communities.

OVERVIEW OF THE IMMIGRANT POPULATION IN THE UNITED STATES

Immigration Status

The 44.9 million foreign-born people residing in the U.S. in 2019 come from all over the world. Over half (22.5 million) are from Latin America, with the largest numbers from Mexico (10.9 million), El Salvador (1.4 million), Cuba (1.3 million), Guatemala (1.1 million) and the Dominican Republic (1.1 million). The Philippines, China, Korea, and India each account for more than one million immigrants living in the U.S., and Asian countries represent the largest source of newly arriving immigrants in the U.S. In terms of race and ethnicity, 44 percent of all immigrants currently living in the U.S. report Latino ethnicity, while 27 percent describe themselves as Asian.¹

The majority of foreign-born individuals have obtained legal status in the U.S. by means of family relationships, sponsored employment, asylee or refugee status, or through the Diversity Visa lottery. More than half (approximately 23.2 million) are naturalized American citizens.² The Department of Homeland Security (DHS) estimates that in 2019, 13.6 million immigrants were lawful permanent residents (LPRs, also known as “green card holders”), of whom 9.1 million were eligible for naturalization.³

The immigration status of refugees and asylees is granted on humanitarian grounds to people who have been persecuted or fear persecution on the basis of race, religion, nationality, membership in a particular social group, or political opinion. Refugees are generally outside of their home country and unwilling or unable to return home. They apply for this status before they enter the U.S. Asylees meet the definition of refugees but are already in the U.S. One year after they have been granted refugee and or asylum status, individuals can file for lawful permanent resident status.⁴ In 2019, 29,916 refugees were admitted to the U.S., with the largest numbers coming from the Democratic Republic of the Congo, Myanmar, and Ukraine, which collectively accounted for 75 percent of the total.⁵ That same year were 46,508 people were granted asylum, with the largest numbers coming from the People’s Republic of China, Venezuela, El Salvador, and Guatemala (accounting for slightly less than half of asylees).⁶

The Migration Policy Institute estimated that there were approximately 11 million undocumented immigrants in the U.S. in 2018.⁷ California and Texas are states with the highest proportion of undocumented immigrants, accounting for 40 percent of the U.S.’s undocumented immigrants, followed by Florida and New York. Six countries of origin account for roughly 75 percent of undocumented immigration: nearly half of undocumented immigrants come from Mexico (approximately 5.42 million people); the next five countries – El Salvador (730,000 people), Guatemala (620,000), Honduras (450,000), India (540,000) and the People’s Republic China (410,000) – together account for an additional 25 percent of the total undocumented population in 2018.⁸

* Documentation status refers to whether an immigrant possesses valid paperwork allowing them to reside in the United States, and if so, they are officially referred to by the Department of Homeland Security as “lawfully present.” Immigrants who have become naturalized citizens are eligible for the same programs as native-born citizens and have very different patterns of health care use compared to non-citizens; accordingly, this Issue Brief primarily focuses on non-citizen immigrants.

As of the end of 2020, the Department of Homeland Security reported, there were over 636,000 active Deferred Action on Childhood Arrival (DACA) recipients in the U.S.⁹ This status, established in 2012, grants temporary deportation relief and authority to work to young people at least 15 years old who meet specified requirements.

Socioeconomic Circumstances of Immigrant Populations

The U.S. Census Bureau collects information on education, employment, and income of all people living in the U.S., including the foreign-born, but it does not collect data on the documentation status of immigrants.*

According to the most recently available Community Population data from 2020,¹⁰ foreign-born persons:

- Are more likely to participate in the workforce than nonimmigrants in the prime working ages of 25-54 (71.8 percent versus 62.2 percent)
- Are more likely to be employed in service (20.6 percent versus 14.4 percent) and maintenance occupations (13.6 percent versus 8.1 percent)
- Had lower median weekly earnings (\$885 versus \$1,000) than native-born workers, among those without a college degree
- Had modestly higher median weekly earnings (\$1,492 versus \$1,409) than native-born workers, among those with a college degree.

The COVID-19 pandemic had a greater effect on employment for the foreign born than the native born. The unemployment rate for foreign-born persons in the U.S. was 9.2 percent in 2020, compared to 3.1 percent in 2019. The jobless rate for native-born persons also increased, but less sharply from 3.8 percent in 2019, to 7.8 percent in 2020.

HEALTH STATUS AND BARRIERS TO CARE AMONG IMMIGRANTS

Health Status of Immigrant Populations

Prior studies comparing health status of foreign-born individuals versus those born in the U.S., most of which focused on Hispanic immigrants, found that on average immigrant populations were healthier and had lower mortality rates compared to their non-immigrant peers with similar demographic and socioeconomic profiles.^{11,12} Consistent with this research, a recent examination of National Health Information Survey (NHIS) data found that self-reported health status of naturalized immigrants was similar to that of the native born (27.1 percent versus 27.9 percent reported excellent health); however, noncitizens, whether here for less than five years (41.6 percent) or more than five years (30.1 percent), were more likely to report their health as excellent.¹³ Immigrant populations have also been found to be less likely to die from cardiovascular disease or cancer, had fewer chronic health conditions, lower rates of obesity, and had lower prevalence of depression and alcohol abuse, compared to the U.S.-born populations¹⁴ Collectively, these generally favorable health indicators among immigrants – despite lower incomes on average – has sometimes been called “the immigrant health paradox.”¹⁵ One important exception is occupational injuries, in which immigrants experience higher rates of injury compared to the overall U.S. population, like in part due to the different types of jobs disproportionately performed by immigrants; furthermore, such rates may be underestimated to the extent that certain injuries go unreported due to concerns about immigration enforcement.¹⁶

However, the health status and prevalence of various conditions varies by specific immigrant populations. For example, an analysis of the NHIS Linked Mortality Files estimated differences in adult mortality among 12

* Information on how the U.S. Census Bureau defines “foreign born,” and what related information they collect, is available here: <https://www.census.gov/topics/population/foreign-born/about/faq.html>.

Hispanic subgroups by region of origin and nativity, adjusting for socioeconomic and demographic characteristics, and found variation in mortality rates of people of Hispanic origin. The analysis indicated that all subgroups of Hispanic immigrant adults ages 65 and over have lower mortality rates than non-Hispanic Whites; however, immigrant Mexicans between ages 25 and 64 had higher mortality compared to non-Hispanic Whites.¹⁷ Factors like the concentration of certain immigrants in low-income neighborhoods and low-wage occupations or unsafe working conditions may contribute to worse health outcomes in some populations.¹⁸ The health status of immigrant populations as a whole is also affected by the characteristics of those who choose to migrate to the U.S., as well as health behaviors including diet, level of physical activity, and smoking.

Different patterns exist in the area of behavioral health. Studies of substance use disorders suggest better outcomes among first generation immigrants do not persist into the second or third generation.^{19,20} While immigrants overall have a lower prevalence of mental health conditions compared to those born in the U.S., those coming from countries involved in wars or other forms of conflict have a higher reported prevalence of mental health conditions.²¹

Barriers to Care and Impacts of Social Determinants of Health among Immigrant Populations

Many immigrants, whether they are undocumented, naturalized citizens, or lawfully present immigrants, face obstacles when seeking health care services. Lack of health insurance coverage is a common challenge, discussed at more length later in this report. Other barriers include cultural and language challenges, such as providers who are frequently not adequately trained to provide culturally competent care or do not take reasonable steps to provide language-appropriate services to ensure effective communication;²² fear of health care providers' collection and reporting of immigration status; and the potential for participation in public programs to affect future immigration status, commonly referred to as "public charge."²³ Collectively, these barriers may impede individuals' decisions to seek care and their ability to take advantage of resources that are available.

Immigration Concerns and Program Participation

Receipt of certain types of government assistance can lead to being denied lawful permanent residence, under the "public charge" designation. Traditionally, this designation was based primarily on the receipt of cash assistance or long-term institutional care, but a 2019 rule expanded its definition to include other forms of non-cash benefits such as Medicaid, Supplemental Nutrition Assistance Program (SNAP), housing assistance and other public benefits. This policy was heavily litigated and created substantial concern and confusion among immigrant communities, resulting in a chilling effect on program participation. An early step of the Biden-Harris Administration was to announce in March 2021 that it would no longer defend the 2019 rule.^{24,25} The Centers for Medicare & Medicaid Services (CMS) sent an informational bulletin to states on July 22, 2021, affirming that receipt of Medicaid (except for institutional services) is no longer a factor in public charge determination and urging states to work with local partners in spreading this message to allay concerns of immigrants who may qualify for Medicaid.²⁶

Also, in 2019, a Presidential proclamation suspended the entry of immigrants who "will financially burden the U.S. healthcare system," and required immigrants to either have approved health insurance coverage within 30 days of entry, or be able to pay for "reasonably foreseeable" medical costs.²⁷ The provision was initially barred from implementation by a U.S. District Court in Oregon. However, the U.S. Court of Appeals for the Ninth Circuit in January 2021 reversed the preliminary injunction.²⁸ In May 2021, President Biden revoked the 2019 proclamation as "not advancing the interest of the United States."²⁹

Several studies suggest that immigration enforcement and other policies can substantially affect immigrant enrollment in public programs, even among those who would not be directly affected by the policy.³⁰ Research suggests that immigration policy related to public charge contributed to fears among immigrant populations about participating in federal health care programs such as Medicaid and the Children's Health Insurance Program (CHIP) or other non-cash assistance programs, and those fears could result in lower rates of health coverage. For example, a 2019 random digit dialing survey conducted in Texas found nearly 1 in 8 low-income Texans had friends or family who avoided public programs or medical care in the past year because of immigration-related concerns.³¹

More broadly, research has found that for families with mixed status (e.g., citizen children born in the U.S. to non-citizen parents), immigrant parents who are not eligible for services often do not realize that their children are eligible or are reluctant to apply for benefits on behalf of their children. Immigrant parents also are reluctant to apply for benefits on behalf of some of their children if other children in the family are not eligible to avoid the appearance of favoring one child over another.³²

However, under the Biden-Harris Administration, these policy barriers to health care participation among immigrant communities have been eliminated, and eligible individuals are able to enroll in Medicaid, CHIP, and SNAP without any impact on their ability to become permanent residents or citizens in the future.

Social Determinants of Health

Other barriers relate to social determinants of health (SDOH), which are living and social conditions that affect a wide range of health, functioning, and quality-of-life outcomes and health risks. SDOH can be grouped into five domains: economic stability, education access and quality, health care access and quality, neighborhood and built environment, and social and community context.³³ Examples of factors that can affect health outcomes include food insecurity, unsafe housing, and limited health literacy, all of which often reflect long-standing systemic inequities in policies. There are reports of high levels of food insecurity among undocumented immigrants: in 2016, 24 percent were reported to be food insecure compared to 14 percent of the general population.*³⁴ These percentages have likely increased during the COVID-19 pandemic, given the widely reported increased demand at the nation's food banks.³⁵

Addressing SDOH is important for improving health equity and minimizing negative outcomes among underserved populations. For example, new immigrant mothers may be particularly vulnerable to poor mental health after childbirth due to cultural isolation, socioeconomic factors, gender roles, and language difficulties that can influence their postpartum experiences.³⁶

Social services can help new immigrants access resources that contribute to better health. Crowded housing is more common in some immigrant communities and has been linked to higher COVID infection rates. For example, in California, with its high cost of living, 18.4 percent of Latinos live in overcrowded conditions, compared to 2.4 percent of Whites.³⁷ However, valuable social support services are not always available to individuals without qualified status.

Foreign-born workers are also more apt to be employed in occupations that expose individuals to health risks than native-born workers. These include service industry, construction, transportation, and maintenance occupations.³⁸

* Estimates are based on a subset of immigrants/refugees.

Low health literacy has been considered by some as a measure of social vulnerability linked to social determinants of health that may be an explanatory factor for some of the health disparities experienced by immigrant populations. However, this has not been well studied.³⁹ Among those most affected by low health literacy are ethnic minorities, those with limited English proficiency, and persons with limited education. As noted earlier, immigrants in the U.S. are a very diverse population, and not all experience these challenges; nonetheless, there is strong evidence that these factors contribute to adverse outcomes in some immigrant communities.

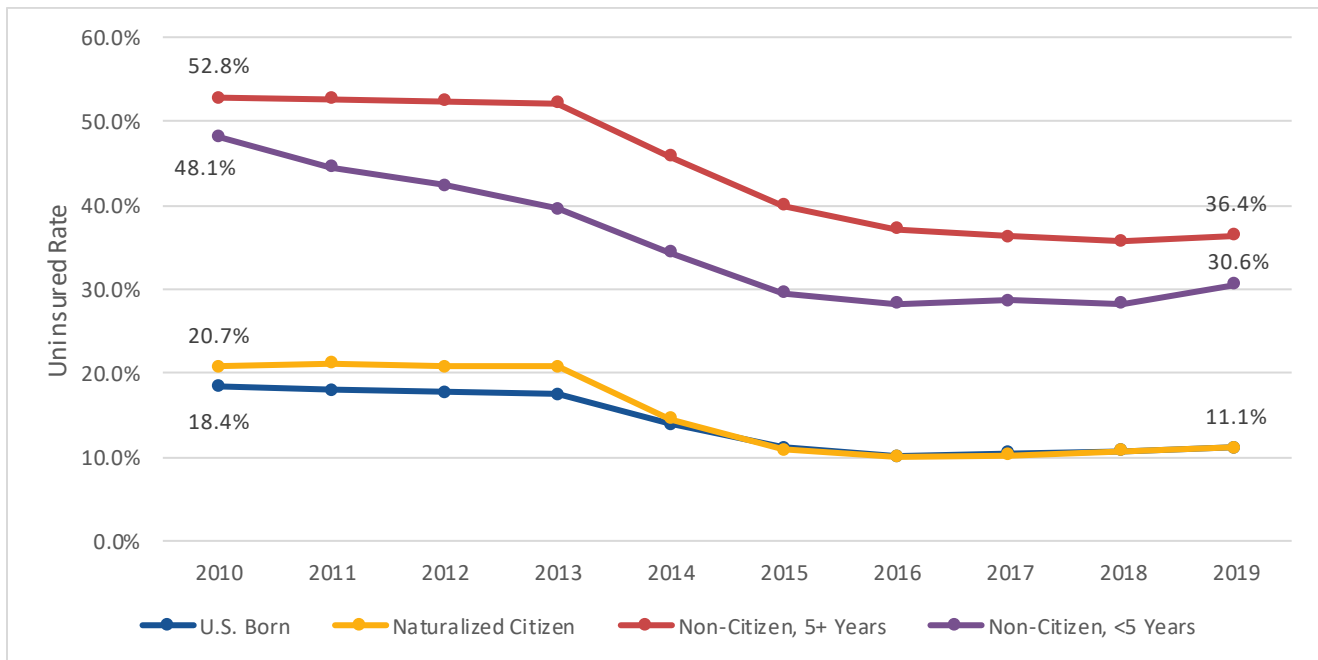
An emerging strategy for addressing the particular social and medical needs some immigrants face is the medico-legal partnership.⁴⁰ These partnerships embed a lawyer within a health care facility to address the legal issues that affect the health of the facility's users. They can help patients with housing issues, eligibility for federal programs, and immigration questions. These partnerships now exist in over 450 health care organizations including 168 HRSA-funded health centers.⁴¹

HEALTH INSURANCE

Noncitizens in the U.S. are much more likely to lack health insurance than citizens. Overall, recent research indicates that 23 percent of documented immigrants and 45 percent of undocumented immigrants were uninsured compared to 9 percent of citizens.⁴² Among the reasons for disparities in coverage, discussed throughout this paper are patterns of employment of immigrants (where employer-sponsored insurance is less common), limited eligibility for public programs for some immigrant groups, changing program requirements, and fear and confusion about consequences of program participation.⁴³

To provide a more complete picture of recent coverage changes among immigrants, we analyzed data from the American Community Survey from 2010 to 2019. Figure 1 shows changes in the uninsured rate from 2010 to 2019 by U.S. nativity, U.S. citizenship status, and years of U.S. residence – i.e., whether living in the U.S. for at least five years, or less than five years. The uninsured rates for all four groups analyzed sharply declined after implementation of the ACA in 2013. U.S. born citizens and naturalized citizens show similar trends and lower uninsured rates than those of non-citizens. Between 2010 and 2019, the uninsured rate declined from 48.1 percent to 30.6 percent among non-citizens residing in the U.S. for fewer than five years, and 52.8 percent to 36.4 percent for non-citizens residing for at least five years. While uninsured rates have improved substantially for non-citizens, disparities in coverage rates between non-citizens and citizens continue to persist. More concerning, uninsured rates among recent immigrants (those living in the U.S. fewer than 5 years) began to rise again in 2018, from 28.2 percent to 30.6 percent.

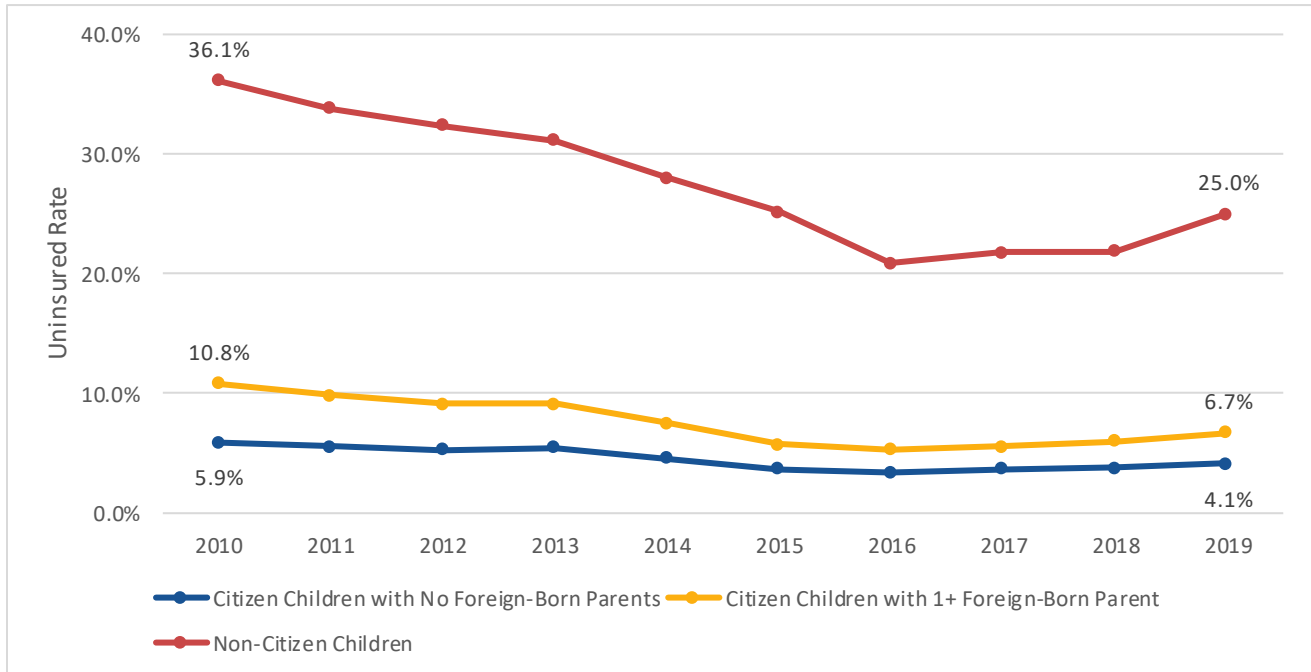
Figure 1. Trends in Uninsured Rates Among Non-Elderly Adults, by Nativity, Citizenship, and Years of Residence, 2010-2019



Source: ASPE analysis of American Community Survey Public Use Microdata Sample data, 1-year estimates, from 2010 to 2019.

Figure 2 describes the trend in the uninsured rate among children by citizenship status and nativity of parents. Citizen children’s coverage rates may vary depending on whether their parents are citizens by birth or foreign-born. The uninsured rates for citizen children are lower than those for non-citizen children, though citizen children with at least one foreign-born parent have higher uninsured rates than citizen children with no foreign-born parents. From 2010 to 2019, the uninsured rate decreased from 36.1 percent to 25.0 percent for non-citizen children, 10.8 percent to 6.7 percent for citizen children with at least one foreign-born parent, and 5.9 percent to 4.1 percent for citizen children with no foreign-born parents. However, similar to recent immigrant adults in Figure 1, the findings indicate a worsening uninsured rate among non-citizen children between 2016 and 2019 (rising from 20.9 percent to 25.0 percent).

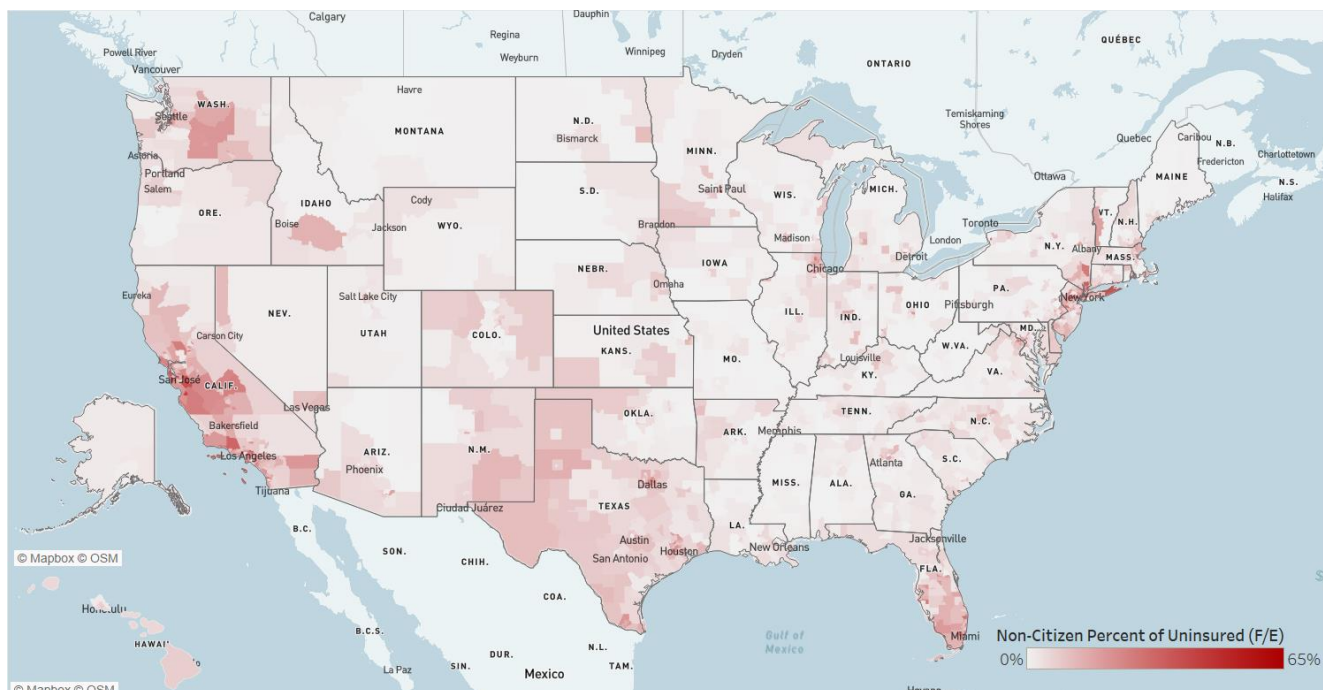
Figure 2. Trends in Uninsured Rates Among Children, by Citizenship and Nativity of Parents, 2010-2019



Source: ASPE analysis of American Community Survey Public Use Microdata Sample data, 1-year estimates, from 2010 to 2019.

Figure 3 illustrates where the uninsured foreign-born population (not including undocumented immigrants) resides in largest numbers across the nation. The map indicates that immigrants comprise a major share of the uninsured population in large parts of states along the Southern border including California, Texas, and Florida, but also in states including Washington, Colorado, and New York. Variation within states in this measure is also substantial.

Figure 3. Percent of Uninsured Who Are Non-Citizens, 2019



Source: ASPE analysis of 2019 American Community Survey Public Use Microdata Sample data.

Note: Figure reflects the percentage of the uninsured population (not including undocumented immigrants) who are non-citizens.

Medicaid, the Children’s Health Insurance Program (CHIP), and Marketplace Coverage

Certain “qualified” non-citizens may be eligible for Medicaid and CHIP, but they are subject to certain eligibility restrictions.⁴⁴ For many qualified non-citizens, including most lawful permanent residents, there is a five-year waiting period after being granted qualified status before they can enroll. Other qualified non-citizens, such as refugees and asylees, do not have to wait five years before enrolling.* Many states have taken advantage of the Children’s Health Insurance Program Reauthorization Act of 2009 to drop the five-year waiting period for children (35 states) and pregnant women (25 states).⁴⁵ Immigrants who have a lawfully present immigration status but do not have a qualified status for purposes of Medicaid and CHIP eligibility, such as those with Temporary Protected Status (TPS),[†] may be ineligible for Medicaid or CHIP (except for treatment of an emergency medical condition) regardless of their length of time in the country, depending on the state in which they reside.[‡] Lawfully present immigrants who are ineligible for Medicaid or CHIP are able to enroll in Marketplace plans, if they meet all other eligibility criteria for coverage.⁴⁶ Non-citizens without a verified

* Afghans with Special Immigrant Visas (SIV) are lawful permanent residents, and they – like refugees and asylees – can also be eligible for Medicaid without a five-year waiting period. If ineligible for Medicaid, arriving Afghan evacuees may be eligible for Marketplace coverage with financial assistance, and if they meet income and eligibility requirements, they can obtain Refugee Medical Assistance for up to eight months post-arrival. Addition details on coverage options for recent Afghan evacuees are available at: Health Coverage Options for Afghan Evacuees, CMS, November 1, 2021 <https://www.medicaid.gov/medicaid/eligibility/downloads/hlth-cov-option-afghan-evac-fact-sheet.pdf>.

† As of March 11, 2021, approximately 320,000 foreign nationals from these 10 countries were protected by TPS: El Salvador, Haiti, Honduras, Nepal, Nicaragua, Somalia, South Sudan, Sudan, Syria, and Yemen. Three countries had been newly designated for TPS: Venezuela on March 8, 2021; Burma on March 12, 2021; and Haiti on May 22, 2021; 35 each for 18 months. See: Congressional Research Service, Temporary Protected Status and Deferred Enforced Departure, Updated May 28, 2021, Temporary Protected Status and Deferred Enforced Departure

‡ TPS is a form of temporary humanitarian relief granted by the Department of Homeland Security to individuals from countries experiencing armed conflict, natural disaster, or other extraordinary circumstances that prevent their safe return that allows these individuals to work and prevents their deportation.

immigration status are not eligible to enroll in comprehensive Medicaid coverage, Medicare, or a Marketplace plan. Those granted deferred action under DACA can be eligible for Medicare if they meet other eligibility criteria, but they are not currently eligible for comprehensive Medicaid or Marketplace coverage.

However, undocumented persons may qualify for emergency Medicaid benefits. States must provide limited coverage of emergency medical services to non-citizens who would qualify for full Medicaid benefits except for their immigration status, including undocumented immigrants.⁴⁷ Emergency Medicaid provides payment for treatment of an emergency medical condition for non-citizens who meet all the eligibility requirements for Medicaid in the state but are not in an immigration status that qualifies them for full benefits. Emergency medical services are defined as services which follow the sudden onset of a medical condition that without immediate attention would cause serious harm to a patient's health.* The services meeting this definition vary by state. For example, through their Medicaid emergency care programs, some states such as Colorado, Washington, Illinois, and Arizona provide patients who have end stage renal disease with regularly scheduled outpatient dialysis services, whereas the majority of states only cover emergency dialysis.⁴⁸ New York requires coverage of chemotherapy and radiation treatment associated with a cancer diagnosis, including prescription medications, as long as they are associated with stabilization and treatment of the diagnosis that constituted the medical emergency.⁴⁹

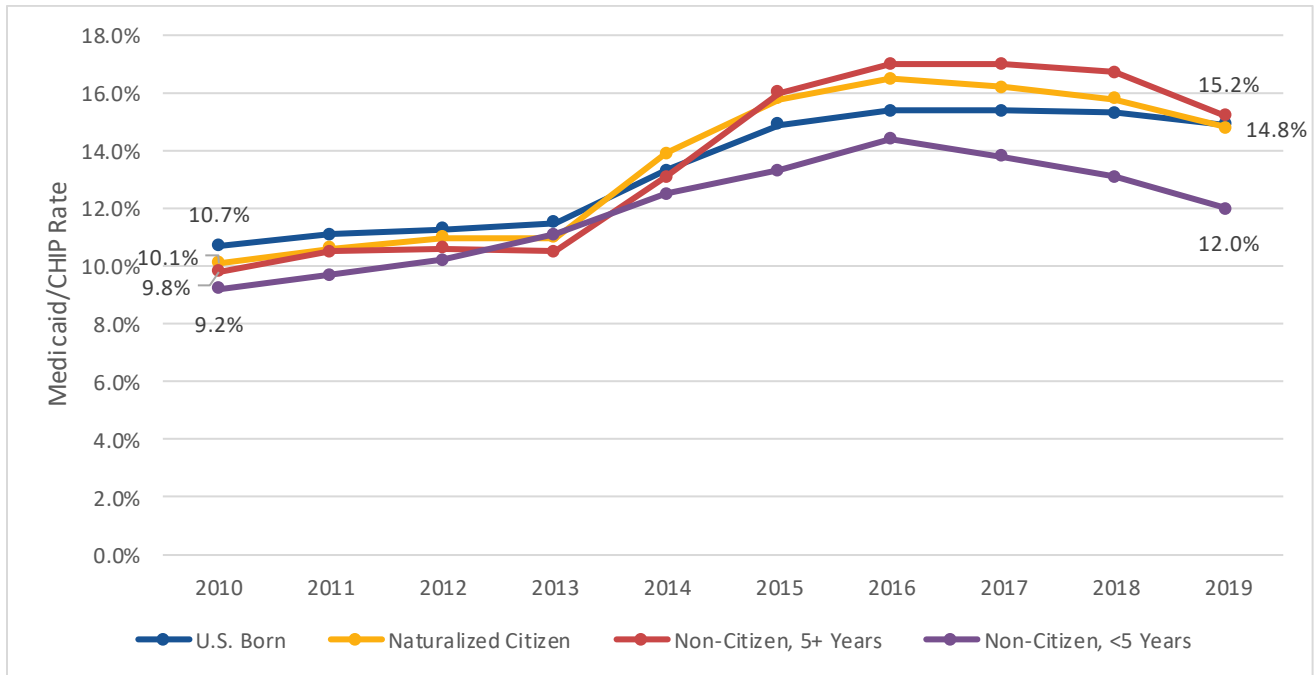
There are also unique Medicaid considerations for the roughly 94,000 citizens of the Freely Associated States who have emigrated to the U.S. from the Federated States of Micronesia, the Republic of the Marshall Islands, and the Republic of Palau. Under the compacts the U.S. has made with these island nations, the U.S. provides certain economic assistance and has exclusive military access over a fixed period, currently 15 years. Their citizens can enter the U.S. as non-immigrants and are eligible to live and work indefinitely in the U.S.⁵⁰ Compact migrants are clustered in a few locations, most notably Guam and Hawaii. Their eligibility for Federal programs varies.⁵¹ While once otherwise eligible individuals qualified for Medicaid, this eligibility was revoked in 1996.⁵² However, the Consolidated Appropriations Act, 2021 of December 2020⁵³ restored Medicaid eligibility to those who otherwise met Medicaid eligibility requirements.⁵⁴ This eligibility was clarified in a letter from CMS to State health Officials on October 18, 2021

We analyzed survey data on Medicaid, CHIP, and Marketplace coverage using ACS as well as Marketplace administrative data, to describe key trends in these coverage types since 2010.

Figure 4 describes trends in Medicaid/CHIP coverage rates among non-elderly adults ages 18-64 from 2010 to 2019. Medicaid/CHIP coverage rates increased across all nativity, citizenship, and years of residence groups after the ACA's Medicaid expansion began to be implemented in 2014. Non-citizens residing in the U.S. for at least five years experienced the greatest increase in Medicaid coverage rate, but with similar increases observed among naturalized citizens and U.S.-born citizens. In 2018-2019, however, Medicaid rates began to fall, particularly among non-citizens who recently immigrated. This timing coincides with the Trump-Pence Administration's efforts to expand the public charge definition and other steps to link immigration status with health care programs, as described earlier.

* See 42 CFR 440.255 Limited services available to certain aliens.

Figure 4. Trends in Medicaid/CHIP Coverage Rates Among Non-Elderly Adults, by Nativity, Citizenship, and Years of Residence, 2010-2019

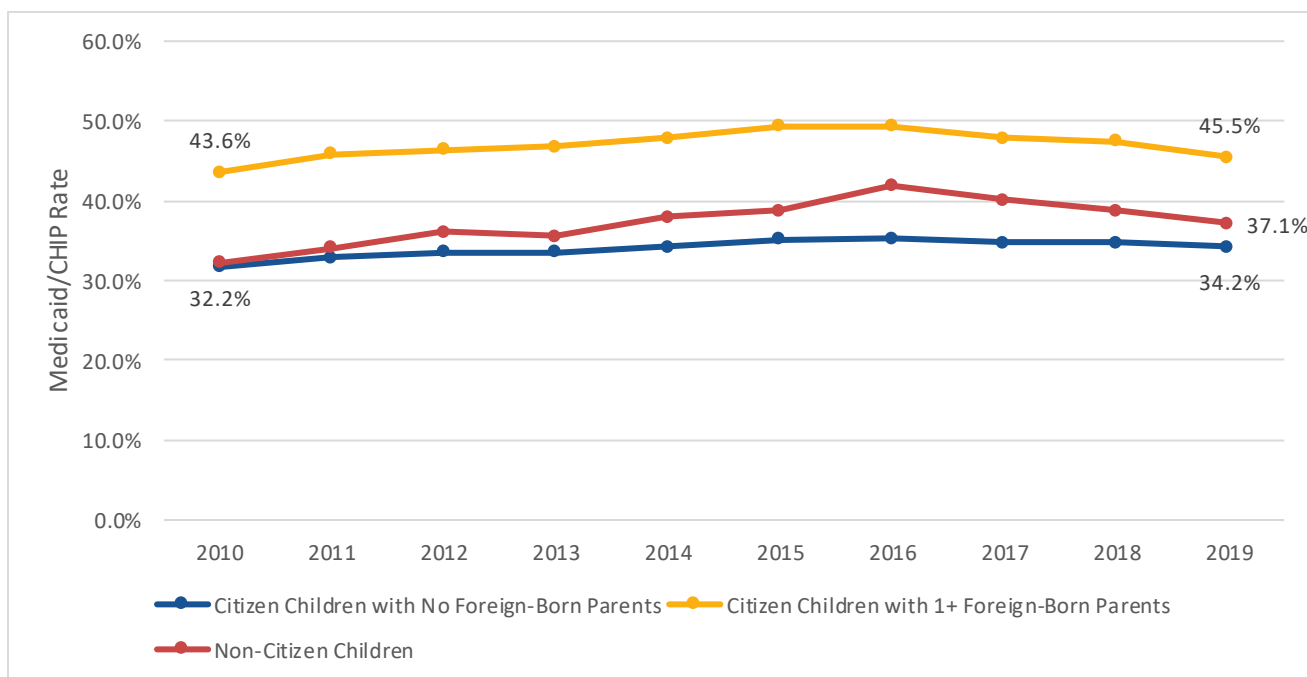


Source: ASPE analysis of American Community Survey Public Use Microdata Sample data, 1-year estimates, from 2010 to 2019.

States have the option of extending Medicaid coverage to documented children and documented pregnant women without applying the five-year wait. As of January 1, 2021, 34 states, DC, and 3 territories cover children and 24 states, DC, and 3 territories cover pregnant women under this option.⁵⁵ Since 2002, states also have had the option to provide prenatal care to income-eligible women regardless of immigration status by extending CHIP coverage to unborn children. As of 2020, 17 states had adopted this option.⁵⁶ Income eligibility levels vary across states from as low as 138 percent of FPL (South Dakota) to as high as 322 percent of FPL (California).⁵⁷

Figure 5 describes changes in Medicaid/CHIP coverage rates among children from 2010 to 2019, by citizenship and nativity of parents. Unlike adults, who experienced a rapid rise in Medicaid coverage after 2014 but declines in more recent years, Medicaid/CHIP coverage rates among children have generally held steady during this time period.

Figure 5. Trends in Medicaid/CHIP Coverage Rates Among Children, by Citizenship and Nativity of Parents, 2010-2019



Source: ASPE analysis of American Community Survey Public Use Microdata Sample data, 1-year estimates, from 2010 to 2019.

If they meet other eligibility criteria, lawfully present immigrants can be eligible to purchase health insurance on the Marketplace and can be eligible for advance premium tax credits without the 5-year wait required by Medicaid. Lawfully present immigrants are eligible to purchase health insurance on the Marketplace and are eligible for advance premium tax credits without the 5-year wait required by Medicaid. Table 1 shows the number of individuals enrolled in Marketplace coverage in HealthCare.gov states, by citizenship status. Nearly 16 percent of enrollees in 2021 were non-citizens in HealthCare.gov states, compared to 13 percent in 2018.

Table 1: Trends in U.S. Citizenship Status and Years of Residence Among Non-Elderly Adult Marketplace Enrollees in HealthCare.gov States, 2018-2021

	2018	2019	2020	2021
Marketplace Enrollment, #	8,744,000	8,412,000	8,287,000	8,252,000
Citizen, %	86.9%	85.8%	85.1%	84.2%
Non-Citizen, %	13.1%	14.2%	14.9%	15.8%

Source: ASPE analysis of MIDAS data. HealthCare.gov states examined include both federally-facilitated marketplaces and state-based marketplaces that use the HealthCare.gov platform, including: Alabama, Alaska, Arizona, Arkansas, Delaware, Florida, Georgia, Hawaii, Illinois, Indiana, Iowa, Kansas, Kentucky, Louisiana, Maine, Michigan, Mississippi, Missouri, Montana, Nebraska, Nevada (removed in 2020), New Hampshire, New Jersey (removed in 2021), New Mexico, North Carolina, North Dakota, Ohio, Oklahoma, Oregon, Pennsylvania (removed in 2021), South Carolina, South Dakota, Tennessee, Texas, Utah, Virginia, West Virginia, Wisconsin, and Wyoming.

Summary of Coverage Trends

Together, these results indicate that the ACA led to a dramatic drop in the uninsured rate for immigrant groups in the U.S., concurrent with the expansion of Medicaid and Marketplace coverage. This is consistent with research indicating that the ACA has expanded coverage among documented immigrants.⁵⁸ For example, a study of health insurance coverage of immigrants in California between 2003 and 2016 found a major decrease

in uninsurance for lawfully present immigrant adults aged 19-64 during that time period, with the uninsured decreasing from 32.1 percent to 18 percent.⁵⁹

In 2018-2019, however, in a policy context less supportive of coverage for immigrants, Medicaid coverage fell and uninsured rates began to climb again for some immigrant populations. Results from 2021 Marketplace data provide encouraging evidence that coverage among non-citizens may be rebounding. Additional survey data will be necessary to track the full impact of recent policy changes in 2021, both related to immigrant populations as well as more broadly (such as the passage of the American Rescue Plan, discussed at more length below).

SAFETY NET PROVIDERS FOR IMMIGRANT POPULATIONS

Some public programs help make health care more accessible for immigrant communities, regardless of immigration status, as discussed below. To increase access to care for foreign-born and immigrant communities they serve, safety net providers may make care more accessible to individuals. Providers and health care organizations who disproportionately serve minority and underserved communities may also take steps to ensure the care they provide is culturally and linguistically tailored at a literacy level that patients and their families can understand and build trust among their communities by structuring their care teams and creating partnerships with local community organizations.

Hospital Services

In some circumstances, hospitals are required to provide services without regard to ability to pay to all comers, including those who may not be documented. For example, the Emergency Treatment and Labor Act (EMTALA) was enacted as part of the Consolidated Omnibus Budget Reconciliation Act of 1986. EMTALA requires that as a condition of participating in Medicare, hospitals that have an emergency room must provide a medical screening examination when a request is made for screening or for treatment of an emergency medical condition, regardless of an individual's ability to pay or immigration status. Hospitals are also required to provide stabilizing treatment for persons found to have emergency medical conditions. If a hospital is unable to stabilize a patient within its capability, or if a patient requests it, an appropriate transfer is required. However, EMTALA does not replace health insurance, as hospitals can still bill for their services and are not required to treat individuals with non-emergency medical conditions.

In certain circumstances, hospitals provide charity care to patients who are determined to be unable to pay their bills, based on the individual hospital's policies. Hospitals are partially reimbursed for uncompensated care (whether charity care or unpaid medical bills) through disproportionate share hospital (DSH) payments by Medicare and Medicaid, as well as through state uncompensated care pools. Non-profit hospitals may include charity care when accounting for the community benefit they provide in order to meet requirements for tax exemption under the federal tax code.

Primary Care and Health Centers

The Health Resources and Services Administration (HRSA) administers the Health Center program. Health centers, frequently referred to as Federally Qualified Health Centers or Community Health Centers, provide affordable, accessible, quality, and cost-effective primary health care to patients regardless of ability to pay, insurance status, or immigration status. Health centers are essential primary care providers for millions of people across the country. Today, approximately 1,400 health centers operate over 13,500 service delivery sites that provide care in every U.S. state, the District of Columbia, Puerto Rico, the U.S. Virgin Islands, and the Pacific Basin. In 2020, health centers collectively served 28.6 million patients—approximately 1 in every 11 people living in the U.S.

Health centers serve a predominantly low-income population. Of the approximately 68 percent of patients in 2020 for whom income was known, 91 percent had incomes below 200 percent of the Federal Poverty Level. Some health centers focus on specific populations such as seasonal and agricultural workers that include a high proportion of immigrants.

Health centers are funded through multiple funding streams. Overall, Medicaid represents the largest single funding source. The second largest funding source is HRSA's Health Center program, which in fiscal year 2021 included \$5.6 billion in base grant funding, plus an additional one-time \$6.1 billion provided through the American Rescue Plan Act. Grants allow health centers to subsidize care for the uninsured and provide services that many immigrant patients benefit from, such as language services, outreach, and community health workers. Other federal grant programs support sites that provide services for the uninsured, including family planning clinics and facilities supported through the Ryan White HIV Program.

State and Local Initiatives

Some states including California, the District of Columbia, Illinois, Massachusetts, New York, Oregon, and Washington cover income-eligible children who are not otherwise eligible due to immigration status using state-only funds.^{60,*} The District of Columbia, Massachusetts, New Jersey, New York, Oregon, and Washington provide some services during pregnancy and in the post-partum period not covered through emergency Medicaid (discussed below) for some income-eligible pregnant patients in the post-partum period who are not otherwise eligible due to immigration status using state-only funds.⁶¹

In several locations across the country with large concentrations of undocumented immigrants, local governments or community organizations have fostered efforts to improve access to care for this population. For instance, Healthy San Francisco, which has been in place since 2006, provides a medical home for primary care and preventive services and a designated site for specialty and emergency services for individuals without other insurance up to 500 percent of the Federal Poverty Level. The program is funded through a mix of city and federal funds, enrollee co-pays, and penalties from employers who do not comply with a local mandate to provide health insurance.⁶²

IMMIGRANTS AND THE COVID-19 PANDEMIC

The COVID-19 pandemic has exacerbated existing disparities in access to care for various populations, even as the public health emergency highlights the importance of health access in responding to infectious diseases.⁶³

Studies show communities with high numbers of immigrants have been affected by the pandemic, with contributing factors including crowded multi-generational housing, lack of insurance coverage, and disproportionate employment in essential jobs and the service economy, placing them at higher risk of contracting COVID-19.⁶⁴ According to a recent report, immigrants are generally at high risk of contracting COVID-19, in part because of their disproportionate frontline employment in essential industries 55 percent of immigrants, and 69 percent of undocumented immigrants hold such jobs compared to 48 percent for the native born.

Under a new "uninsured individuals" eligibility category created by the Families First Coronavirus Response Act,⁶⁵ states have the option to provide coverage through Medicaid for COVID-19 testing for immigrants with

* California also covers income-eligible young adults up to age 26 in this way. See: https://www.dhcs.ca.gov/services/med-cal/eligibility/Pages/youngadult_exp.aspx.

qualifying status.* The U.S. Citizenship and Immigration Services (USCIS) stated in 2020 that it would not consider COVID-19 testing, treatment, or preventive care services in a public charge determination, even if those services were paid for by Medicaid.⁶⁶ In addition, DHS stated that it supports equal access to the COVID-19 vaccines for undocumented immigrants and encourages all individuals, regardless of immigration status, to receive the COVID-19 vaccine.⁶⁷ However, these complex program details are challenging to communicate easily to immigrant communities and may not fully assuage immigrants' underlying "public charge" concerns as to potential adverse consequences if they do seek such services.

The COVID-19 Uninsured Program, operated by HRSA, covers testing, treatment, and immunization services without cost to anyone who is uninsured, regardless of immigration status. Although individuals do not need to provide documentation to receive these services and vaccination is available at no charge, some immigrants have reported facing barriers to COVID-19 vaccination. To counter these and other access barriers, HRSA has conducted extensive outreach to immigrant groups, providers, and other stakeholders to promote awareness of no-cost access to COVID-19 services for patients, ensure providers know claims without patient insurance or identification information can still be reimbursed, and reaffirm that use of these services will not affect anyone's immigration status or be shared with immigration agencies. HRSA also established a program of direct distribution of vaccines to health centers to address access challenges and promote equity. The program initially targeted health centers that served large numbers of individuals experiencing homelessness, public housing residents, migrant/seasonal agricultural workers, and patients with limited English proficiency, but was eventually expanded to all health centers. As of November 5, 2021, HRSA's Health Center program has provided first or second dose COVID vaccines to 15.9 million people, 67 percent of whom are people of color. This total likely includes many immigrant patients.⁶⁸

POTENTIAL POLICY APPROACHES TO IMPROVE HEALTH CARE EQUITY FOR IMMIGRANTS

Expanding Insurance Coverage

As noted earlier, the ACA created new options for affordable health insurance for millions of documented immigrants, and the American Rescue Plan Act of 2021 (ARP) substantially enhances the generosity of premium subsidies for Marketplace coverage, which likely will extend coverage to many more lawfully present immigrants. Changes included in the ARP are estimated to increase the availability of zero-premium and low-premium Marketplace plans after premium tax credits in HealthCare.gov states by 19 and 16 percentage points, respectively, among all uninsured eligible for these plans. The ARP also substantially increased the availability of low-premium silver and gold plans.⁶⁹

Other **potential** policy steps to further expand coverage among immigrant communities could include:

- Conducting outreach and engaging local trusted partners to help inform documented immigrants and their families about the ARP's temporary expanded eligibility and subsidies.
- Encouraging expansion of Medicaid in states that have not already done so, including several with large immigrant populations.
- Communicating recent changes in federal policy, including those around public charge and DACA, through public education efforts and via trusted community messengers.
- Consider establishing Medicaid or Marketplace plan eligibility for DACA recipients and/or eliminating the 5-year waiting period for Medicaid among lawful permanent residents.

* As of May 2020, twenty states offered this optional Medicaid eligibility category to cover COVID-19 testing for uninsured individuals. Dolan R and S Artiga. State Actions to Facilitate Access to Medicaid and CHIP Coverage in Response to COVID-19. <https://www.kff.org/coronavirus-covid-19/issue-brief/state-actions-to-facilitate-access-to-medicaid-and-chip-coverage-in-response-to-covid-19/>

- Expansion of Medicaid/CHIP prenatal coverage to undocumented immigrants under the current state “unborn child” option.
- Encouraging state-only coverage of family planning services.
- State-funded initiatives to expand insurance coverage like those already implemented in some states (e.g., California’s state funded expansion of undocumented young adults up to age 26, other states’ coverage of children).

Health and Social Services

Many federal programs address the health and social service requirements of high-need populations. A broad focus addressing equity across such programs could produce important gains in access to services for immigrant populations. Potential areas of focus include:

- Targeting new or expanded safety net efforts (and reinforcing existing efforts) to areas that have disproportionately large populations of immigrants with unmet health care and social service needs.
- In grant-funded programs, encouraging program links to immigrant communities through hiring members of the community, use of community health workers, language services, and multilingual hotlines to triage calls and connect people to care.
- Funding services that address social determinants of health such as subsidizing transportation services; customizing interventions based on immigrants’ diverse cultural traditions (e.g., diet and traditional foods), medico-legal partnerships, and addressing housing challenges.
- Ensuring that culturally and linguistically competent health and social services are available, with appropriate training in these areas for providers and consumer-facing organizations and ensuring compliance with federal civil rights laws⁷⁰ that require recipients of HHS funding to take reasonable steps to ensure meaningful access to their programs or activities by limited English proficient individuals, which may require provision of language assistance services.

COVID-19 Outreach to Immigrant Communities

While much progress has been made in raising COVID-19 immunization levels and access to testing, there are still geographic areas and populations where rates lag. Targeted efforts to improve access to services and protect immigrant populations could include:

- Providing language-appropriate and medically accurate information regarding COVID-19 testing and immunization to improve access to COVID-related services.
- Raising awareness through a culturally and linguistically tailored multi-level and multi-lingual public education campaign
- Improving referrals to community-based services to address social needs identified through improved data collection noted below
- Improving workplace safety for essential workers, who are disproportionately represented among immigrant populations

Improving Data on Race/Ethnicity, Language, and SDOH

- Improving routine collection and analysis of data related to race/ethnicity, spoken and written languages, and social determinants of health in public program administrative data is critical to promoting policies that better meet the needs of immigrant communities.
- Developing, testing, and applying improved techniques for imputing missing data elements related to immigrant populations can improve the usefulness of existing data to address health disparities
- Addressing knowledge gaps through research with a special focus on policy changes and impacts on coverage, utilization, and health is needed to inform both national and state-specific efforts to improve health equity for immigrant populations.

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**SUGGESTED CITATION**

Health Insurance Coverage and Access to Care for Immigrants: Key Challenges and Policy Options (Issue Brief No. HP-2021-26). Washington, DC: Office of the Assistant Secretary for Planning and Evaluation, U.S. Department of Health and Human Services. December 2021.

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