kaiser commission on medicaid and the uninsured
KEY FACTS
THE HENRY J. KAISER FAMILY FOUNDATION

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HEALTH COVERAGE FOR IMMIGRANTS

Health coverage for immigrants remains a pressing policy challenge. Although most immigrants are in working families, many work in jobs that do not offer health insurance. Federal law has restricted Medicaid and SCHIP eligibility for many immigrants since 1996. As a result of limited private and public coverage, immigrants have high uninsured rates, and, as such, experience difficulties accessing care. In response to the federal restrictions on Medicaid and SCHIP, a number of states have stepped in with replacement programs. As of 2004, some 25 states offered state-funded coverage to immigrants and/or used an available SCHIP option to provide prenatal care without regard to immigration status.

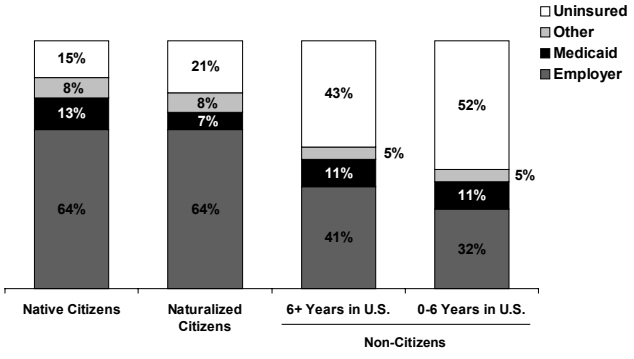
In 2003, about 33.5 million immigrants were living in the United States, representing about 12% of the population. While immigrant health issues have often been viewed as a concern for a few states, increases in immigration over the last 20 years, as well as increasing dispersion of immigrants around the country, have made immigrant health issues an increasingly important matter of national concern.

IMMIGRANTS AND HEALTH CARE COVERAGE

Immigrants are significantly more likely to be uninsured than native citizens. Over half (52%) of recent immigrants were uninsured in 2003, compared to 15% of native citizens (Fig. 1). In 2003, noncitizens accounted for 22% of the 45 million people without health coverage.

Figure 1

Health Insurance Coverage by Citizenship Status, 2003



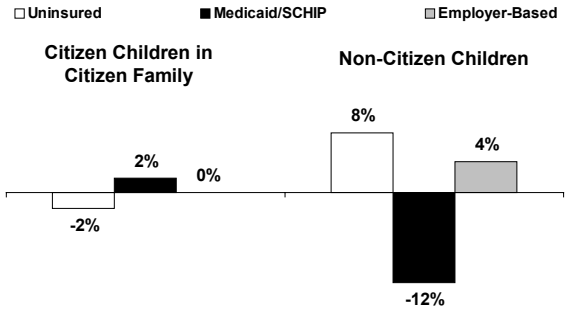
Notes: Based on nonelderly population. Other includes private non-group, Medicare, and CHAMPUS.
Source: Urban Institute and Kaiser Commission on Medicaid and the Uninsured analysis of March 2004 Current Population Survey.

These disparities in coverage are not explained by differences in work effort. Over 80% of immigrants have a full-time worker in the family, and low-income immigrant families are more likely to include a full-time worker than low-income native families. However, a disproportionate number of immigrants work in low-wage jobs that are less likely to offer health benefits. Thus, while nearly two thirds of citizens had employer health coverage in 2003, about one-third of recent noncitizens had employer-based coverage (Fig. 1).

The disparity in health coverage between immigrants and citizens has widened since the enactment of restrictions on immigrants' eligibility for public coverage under the 1996 Personal Responsibility and Work Opportunity and Reconciliation Act (PROWRA). The number of low-income legal immigrants with health coverage significantly declined despite an increase in the share of low-income immigrants with employer-based coverage. These increases were more than offset by sharp declines in Medicaid coverage among noncitizens. For example, the proportion of low-income noncitizen children with Medicaid and SCHIP decreased by 12 percentage points between 1995 and 2001 (Fig. 2). Immigrants have not been primarily responsible for the overall recent increase in the number of uninsured despite their significant coverage declines.

Figure 2

Percentage Point Change in Insurance Coverage for Low-Income Children, 1995-2001



Notes: Low-income is less than 200% of poverty. Beginning with the March 2001 Current Population Survey, the Census Bureau changed its method of determining who is uninsured by adding a "verification" question. Because "verified" data are not available for 1995, the changes shown here use "pre-verification" insurance data from the March 1996 and 2002 CPS.
Source: Ku and Waidmann, "How Race/Ethnicity, Immigration Status, and Language Affect Health Insurance Coverage, Access to Care, and Quality of Care Among the Low-Income Population," KCMU, August 2003.

Lack of coverage has important health consequences and contributes to severe disparities in access to care between noncitizens and citizens. Immigrants are less likely than other individuals to have a regular source of care, to visit a doctor, or to obtain preventive care.

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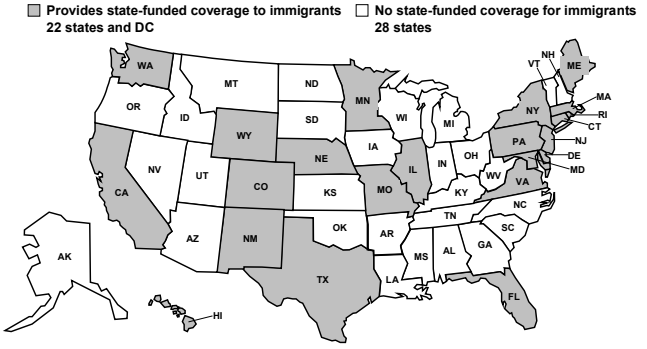
STATE RESPONSES TO ELIGIBILITY RESTRICTIONS

A number of states have undertaken efforts to help address the coverage limitations imposed on immigrants by the 1996 PROWRA law. As of 2004, nearly half (23) used state funds to provide coverage to some or all legal immigrants who are ineligible for Medicaid or SCHIP because of the restrictions (Fig. 3). Some states also used these programs to extend coverage to undocumented immigrants—particularly children and pregnant women—who were ineligible for Medicaid prior to 1996. Additionally, seven states, including two states that do not provide any state-funded coverage for immigrants, used a recently available option to provide SCHIP-funded prenatal care regardless of the mother's immigration status.

Figure 3

State-Funded Coverage for Immigrants Who are Ineligible for Medicaid or SCHIP, May 2004

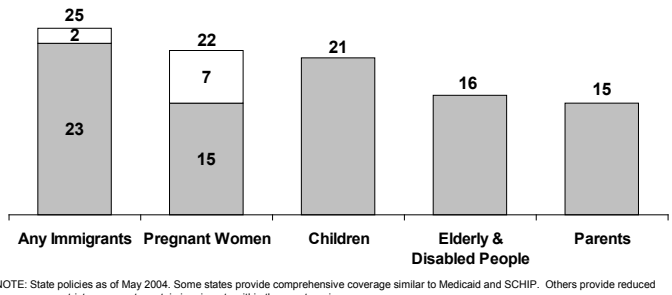


NOTES: In some cases coverage is only available to limited categories of immigrants and/or is substantially more limited than Medicaid or SCHIP coverage. Arkansas, Illinois, Massachusetts, Michigan, Minnesota, Nebraska, and Rhode Island use federal SCHIP funds to provide prenatal care coverage regardless of immigration status.

In total, 25 states provided state-funded coverage and/or used the SCHIP option to provide prenatal care without regard to immigration status. States most commonly provided coverage to some or all immigrant children or pregnant women (Fig. 4).

Figure 4

State Coverage for Immigrants, 2004



NOTE: State policies as of May 2004. Some states provide comprehensive coverage similar to Medicaid and SCHIP. Others provide reduced coverage or restrict coverage to certain immigrants within these categories.

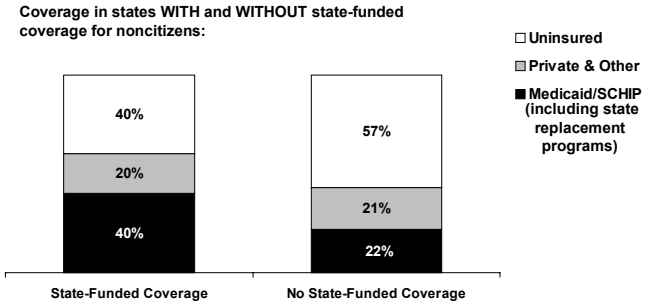
Most of the state-funded programs for immigrants have the same scope of coverage and rules as Medicaid (or SCHIP). However, some states only provide the coverage to very limited categories of immigrants. Further, a few provide coverage that is significantly more limited than Medicaid or SCHIP or that has rules that can limit participation, such as premiums, cost sharing, more burdensome enrollment procedures, and enrollment caps.

In addition to providing state-funded coverage, some states have worked to reduce enrollment barriers for immigrants who remain eligible for Medicaid and SCHIP and to improve immigrants' access to care. Some have made efforts to reduce confusion around eligibility, to reduce language barriers, and to alleviate concerns about potential negative impacts of enrolling in coverage on immigration status.

State-funded coverage programs for immigrants and other state efforts appear to be effective in reducing uninsured rates among immigrants. Noncitizen children living in states with state-funded programs have lower uninsured rates than such children living in states without programs (Fig. 5).

Figure 5

Health Insurance Coverage Among Low-Income Noncitizen Children, 2002



Note: Low-income is less than 200% FPL. Analysis excludes states that have state-funded programs that are more limited than Medicaid, are subject to enrollment or funding caps, or provide coverage to limited types of legal immigrants who are ineligible for Medicaid. States excluded completely from the analysis of children's coverage are the District of Columbia, Florida, New Mexico, and Texas. Other coverage includes private coverage and other public coverage, including Medicare and Veterans' benefits.
Source: Center on Budget and Policy Priorities' analysis of Mach 2003 Current Population Survey Data.

POLICY IMPLICATIONS

The 1996 limits on Medicaid and SCHIP eligibility for immigrants contributed to high uninsured rates, widened the disparity in coverage between immigrants and native citizens, and increased immigrant coverage disparities across states. In 2004, nearly half of states had replacement health coverage programs for immigrants, and it appears these efforts have been successful in helping to stem the impact of the restrictions. Overall, however, immigrants continue to face significant challenges accessing coverage and care. Further, as states have faced fiscal pressures, a few have cut or considered cutting these programs. The lack of federal funding for coverage of many immigrants means that individual states must bear the responsibility of financing their care. As a result, certain states disproportionately bear this responsibility and immigrants' coverage is vulnerable when states face fiscal problems.

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