Geiger Gibson /
RCHN Community Health Foundation Research Collaborative
Policy Research Brief No. 7

Restoring Medicaid and SCHIP Coverage to Legal immigrant Children and Pregnant Women: Implications for Community Health and Health Care for Tomorrow's Citizens

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January 13, 2009

About the Geiger Gibson / RCHN Community Health Foundation Research Collaborative

The Geiger Gibson Program in Community Health Policy, established in 2003 and named after health center and human rights pioneers Drs. H. Jack Geiger and Count Gibson, is part of the School of Public Health and Health Services at The George Washington University. It focuses on health centers, their history and contributions, and the major policy issues that affect health centers and the communities and patients they serve.

The RCHN Community Health Foundation, founded in October 2005, is a not-for-profit operating foundation whose purpose is to support community health centers through strategic investment, advocacy, education, and cutting-edge health policy research. The only foundation in the country dedicated to community health centers, the Foundation builds on a 40-year commitment to the provision of accessible, high quality, community-based healthcare services for underserved, medically vulnerable populations. The Foundation's gift to the Geiger Gibson program supports health center research and scholarship.

Introduction

In the coming weeks, Congress will consider the reauthorization of the State Children's Health Insurance Program (SCHIP), whose legislative authorization will expire on March 31, 2009. SCHIP's overarching goal, in tandem with Medicaid, is to assure coverage of low-income children, regardless of race or national origin. As the proportion of uninsured immigrant children grows, a crucial question is whether the SCHIP reauthorization will address the need to restore eligibility for legal immigrant children and pregnant women. Although SCHIP and Medicaid have been successful in improving health insurance coverage for most low-income American children since the mid-1990s, the health coverage gaps for immigrant children have deepened and about half of all low-income immigrant children are now uninsured.

SCHIP reauthorization represents a critical opportunity to restore access to Medicaid and SCHIP coverage for some of the most vulnerable children and pregnant women, those who are legally-admitted immigrants. (Undocumented immigrants would remain ineligible for Medicaid and SCHIP, as they always have been, except for coverage of emergency care under Medicaid.) Welfare reform legislation passed in 1996 requires that most legal immigrants wait for five years before qualifying for coverage under Medicaid, regardless of how poor or sick they are.[1] While numerous Senators and Congressmen from both sides of the aisle have supported proposals to allow states to restore coverage for legal immigrant children and pregnant women, they have yet to come to a full vote before both chambers of Congress.

The lack of coverage makes it harder for these children and pregnant women to get necessary health care, especially if they lack access to a health center or other safety net provider. Thus, they may fail to receive immunizations or prenatal care, which are needed to grow up healthy. The restoration of Medicaid and SCHIP would enhance health centers' ability to furnish care for more needy patients in the community, by freeing up funds now used for uncompensated care.

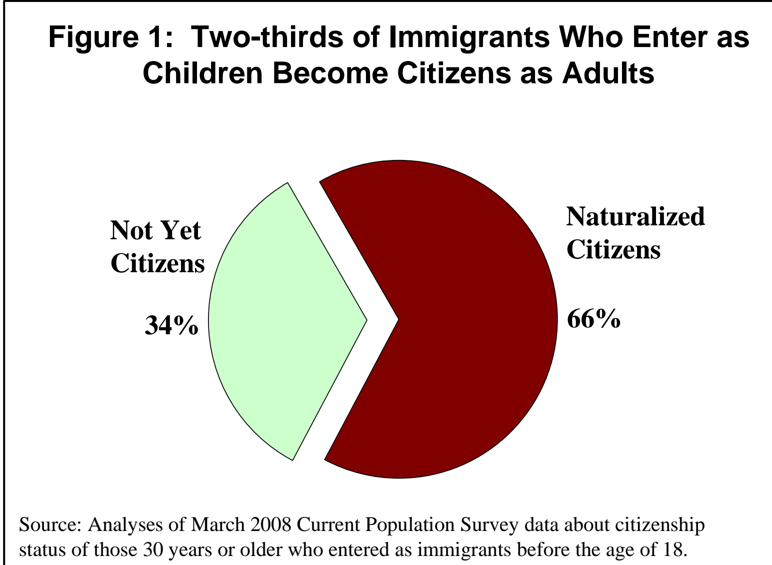
Barring coverage for legal immigrant children and pregnant women jeopardizes community health while discriminating against future citizens, workers and family members. Restoring Medicaid and SCHIP coverage to these vulnerable populations will improve their health and strengthen their ability to contribute to the nation and economy.

Most Immigrant Children Become U.S. Citizens

Today's immigrants become tomorrow's citizens. Census data show that most immigrants who enter the U.S. when they are children become U.S. citizens. In addition, infants born in the U.S. of pregnant immigrants are citizens at birth. Regardless of whether they become citizens or not, the children will grow up to be adults who work hard, make contributions to the U.S. economy, pay taxes, start businesses, serve in the military and participate in American civic life.

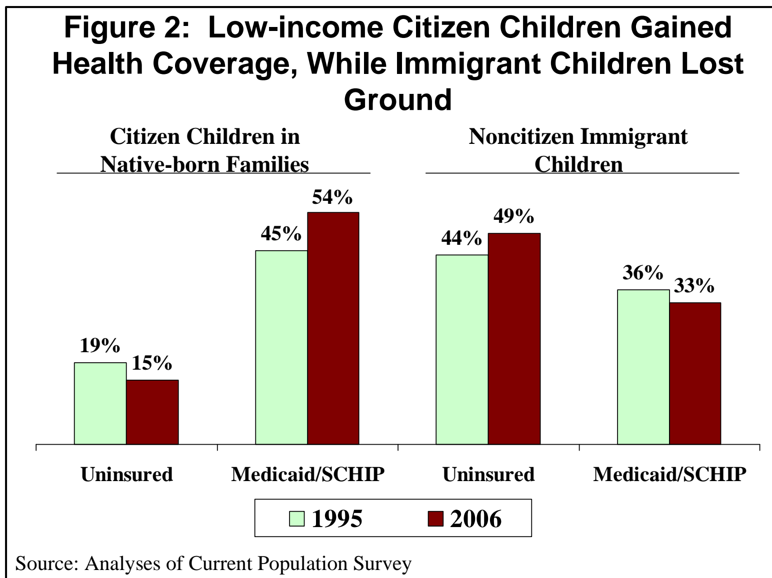
[1] Ku, L. "Improving Health Insurance and Access to Care for Children in Immigrant Families," *Ambulatory Pediatrics,* 7(6):412-20, November 2007.

Analyses of the Census Bureau's Current Population Survey for March 2008 indicate that two-thirds (66%) of adults 30 years and older who entered the U.S. as immigrant children (that is, were under 18 years of age when they entered the country) became naturalized citizens (Figure 1). The longer they stay in the U.S., the more likely immigrants are to become citizens: more than three-quarters (77%) of immigrants 40 or older who entered as children became naturalized citizens, while about 90% of those 60 or older became citizens.



The Gap in Health Coverage Between Citizen and Immigrant Children Has Widened

Since the late 1990s, the enactment of SCHIP and the expansion of Medicaid coverage have helped millions of American children gain access to health insurance coverage as well as affordable health care; these gains have been a major policy success during a period when so many adults were losing their health insurance coverage. But while most children were gaining health insurance coverage, children who are immigrants were losing health insurance and the gaps between citizen and immigrant children widened. Under the 1996 welfare reform law, legally-admitted noncitizen children who entered the country within the past five years are ineligible for Medicaid or SCHIP coverage, simply because of their immigration status. They have been left out of the substantial gains in health insurance coverage that helped millions of other children.



The erosion in health insurance coverage has hit immigrant children particularly hard. Data from the Census Bureau show that between 1995 and 2006, the percentage of low-income citizen children (with incomes below 200 percent of the poverty line) whose parents are native-born citizens without health insurance declined from 19% to 15% (Figure 2). This was primarily because millions of

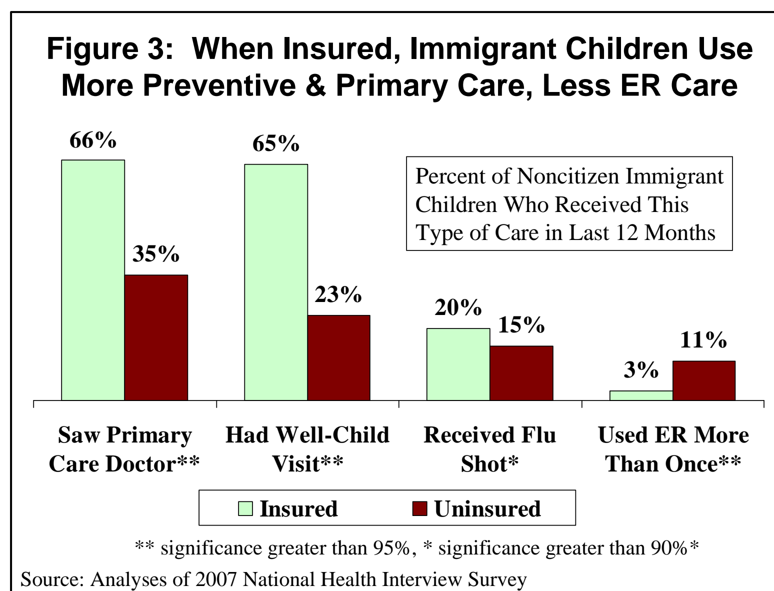
children were able to enroll in Medicaid or SCHIP. In contrast, low-income immigrant children grew even more uninsured than they had been a decade earlier, largely because they were denied Medicaid or SCHIP benefits. The percentage of immigrant children who are uninsured rose from 44% in 1995 to 49% in 2006, primarily because of reductions in Medicaid and SCHIP coverage.

The disparities in coverage between citizen and immigrant children – which were already wide in 1995 – became even more profound in the following decade.

When Immigrant Children Are Insured, They Receive More Primary and Preventive Health Care and Use the Emergency Room Less

Under current federal law, legal immigrant children who entered the country within the preceding 5 years are barred from Medicaid, and because of Medicaid's link to SCHIP, they also fail to secure coverage through that pathway. This policy, like other policies that inhibit ready access to insurance coverage, is counterproductive because it promotes the use of expensive emergency room care, while discouraging the use of lower-cost services that keep people healthy and help manage costly and chronic illness.

Analysis of the 2007 National Health Interview Survey shows that when immigrant children are insured, they make more effective use of health care services. For this research brief, we compared the health care use over the prior 12 months for non-citizen immigrant children who were insured and those who were uninsured. As seen in Figure 3, immigrant children who are insured are about twice as likely to have seen a primary care doctor in the last year as those who are uninsured (66% insured vs. 35% uninsured). When they are insured, immigrant children are three times as likely to have preventive well-child visits as uninsured children (65% insured vs. 23% uninsured). Insured immigrant children are also more likely to get a flu shot (20%) than uninsured immigrants (15%).



In contrast, uninsured immigrant children are almost four times as likely to have used an emergency room more than once during the prior year as immigrant children who are insured (2.7% insured vs. 10.8% uninsured). In many cases, children use emergency rooms as a result of illnesses (such as asthma or the flu) that could have been prevented or better controlled by primary health care services. In other cases, they turn to emergency rooms because they simply lack access to a regular source of primary health care. (It is worth noting that the CDC data also

show that emergency room usage is generally higher for U.S.-born children than for immigrant children, so the belief that uninsured immigrants are the cause of crowding in emergency rooms is unsubstantiated.) Reinstating Medicaid coverage for immigrant children thus carries both immediate and downstream cost savings while resulting in higher quality care.

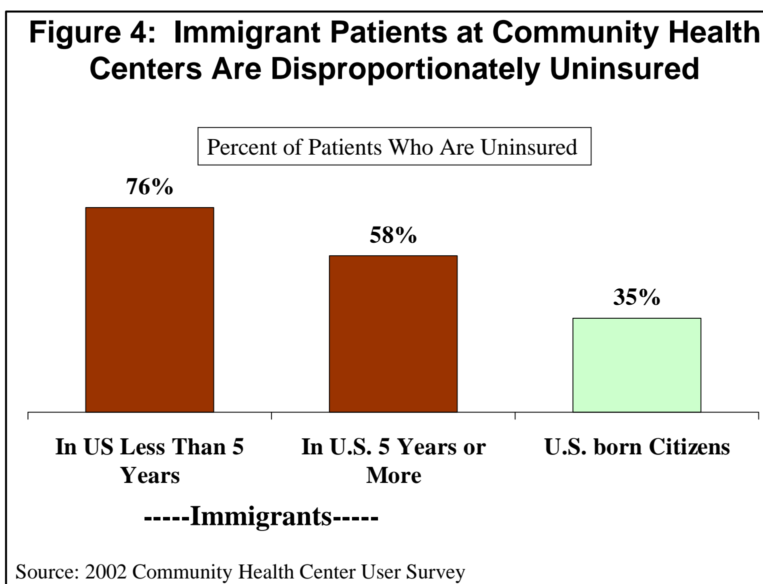
Research has also shown the importance of insurance coverage for pregnant immigrants. One study of pregnant immigrants showed the linkage of Medicaid coverage for pregnant immigrant women and their use of prenatal care. Hispanic women who were legal immigrants in Florida had considerably less access to prenatal care than similar women in New York; a key difference is that New York provided Medicaid coverage to pregnant immigrants, while Florida did not.[2] Adequate prenatal care helps increase the chance that women have healthy babies and the children do not incur expensive neonatal care costs. Restoring coverage can help assure that these women are able to deliver healthy babies, who will be American-born citizens.

The Lack of Medicaid and SCHIP Eligibility Creates Additional Burdens for Safety Net Health Care Providers

Recent legal immigrants who are not eligible for Medicaid or SCHIP coverage disproportionately seek care from safety net health care providers, such as community health centers. Federally qualified community health centers furnished primary care services to 16 million patients in 2007, of whom 39% were uninsured and 91% had low incomes (with incomes below twice the poverty line).

A large number of patients receiving care at community health centers are immigrants, and they are disproportionately uninsured. A 2002 survey of patients receiving care at community health centers nationwide revealed that 76% of patients who were immigrants who had been in the U.S. for less than five years were uninsured, compared to 58% of the immigrants who had been in the U.S. for five years or more and 35% of those who were native-born citizens (Figure 4).

Figure 4: Immigrant Patients at Community Health Centers Are Disproportionately Uninsured



Source: 2002 Community Health Center User Survey

The survey indicated that about one-sixth (16%) of health center patients seen in 2002 were immigrants. The level is expected to have climbed since then. Although administrative data reported by all health centers in 2002 and, more recently, 2007 do not report the immigration status of patients, we can make some reasonable inferences about changes based on related data. Between 2002 and 2007, the

[2] Fuentes- Affleck, E. et al. "Use of Prenatal Care by Hispanic Women after Welfare Reform," *Obstetrics and Gynecology*, 107(1):151-60, Jan. 2006.

number of uninsured patients climbed 42 percent, the number of patients preferring to speak in languages other than English grew by 31 percent, and the number of migrant and seasonal farmworkers and their families increased by 17 percent. These data suggest that the number of health center patients who are immigrants has grown considerably in the past several years.

If legal immigrants were eligible for Medicaid and SCHIP, fewer of the immigrants being cared for at community health centers would be uninsured. The Medicaid and SCHIP insurance revenues that could be available to health centers would help them to expand services and extend primary care to even more uninsured patients, including uninsured citizens and immigrants alike.

Federal Coverage Would Restore Federal Funding for Many States and Provide New Opportunities for the Rest

Despite the denial of federal funding for coverage of legal immigrants who have lived in the U.S. for less than five years in Medicaid and SCHIP, 21 states provide supplemental coverage for legal immigrant children, and 16 states provide coverage for pregnant women using state funds without federal matching support (see the table on the next page). Giving states the option to restore Medicaid and SCHIP coverage to legal immigrant children and pregnant women would restore the federal funding lost as a result of the 1996 legislation and would offer fiscal redress to the states that continued to provide health coverage for legal immigrants, while providing new opportunities for those states that did not.

Federal funding would help ensure that the states listed below can continue to provide coverage to legal immigrant children and pregnant women during the current economic downturn. In the past, states like Rhode Island or Florida have curtailed coverage for legal immigrant children, largely because federal matching funds were not available. Other states, like Iowa, that wanted to restore coverage to legal immigrants have been unable to do so because of the lack of federal funding.

Cover Legal Immigrant Children	Cover Legal Immigrant Pregnant Women
Alaska*	Alaska*
California	California#
Connecticut	Colorado
Delaware	Connecticut
District of Columbia	Delaware
Florida*	District of Columbia
Hawaii	Hawaii
Illinois	Illinois#
Maine	Louisiana#
Maryland	Maine
Massachusetts	Maryland
Minnesota	Massachusetts
Nebraska	Michigan#
New Jersey	Minnesota#
New York	Nebraska#
Ohio*	New Jersey
Pennsylvania	New York
Texas	New Mexico*
Virginia	Ohio*
Washington	Pennsylvania
Wyoming	Rhode Island#
	Tennessee#
	Texas#
	Washington
	Wisconsin#
	Wyoming*

* State provides coverage to a limited subset of the legal immigrant children or pregnant women.

State uses the SCHIP prenatal option to cover pregnant women and already receives federal matching funds for coverage of those pregnant women.

Technical Notes

Figure 1. The Census Bureau's March 2008 Current Population Survey collects information about the current citizenship status of respondents, whether they were born as U.S. citizens and when they entered the U.S. This analysis examined adults 30 years or older who were foreign-born (and who were not citizens because they were born to U.S. citizens living abroad or born in U.S. territories) and who immigrated to the U.S. before the age of 18. Two-thirds (66%) of adults 30 or older became naturalized citizens. The Census data do not indicate whether a person was a legal immigrant or not when he or she entered the United States, so these statistics are for all those who entered as immigrant children. Because this analysis is based on those now living in the U.S., it excludes those who entered as immigrant children, but who have since died or left the U.S. It is reasonable to believe that the percentage of legally-admitted immigrant children who become citizens is even higher than 66% because they are more likely to remain in the U.S. for the rest of their lives than those who entered without documentation, so these are conservative estimates.

Figure 2. The March Current Population Survey also measures health insurance coverage of individuals during the prior year. This analysis uses data from the March 1996 and March 2007 surveys. Citizen children in native-born families are those whose parents were U.S.-born citizens. Noncitizen immigrant children are those who were foreign-born and have not yet naturalized. Since the survey does not indicate the legal status of immigrants, it includes both legally present and undocumented immigrants. Between 1996 and 2007, the Census Bureau introduced changes in how it measures health insurance coverage, so the trends are not completely comparable over that period.

Figure 3. These analyses are based on the 2007 National Health Interview Survey, a nationally representative health survey conducted by the Centers for Disease Control and Prevention. All analyses are calculated using survey weights and adjust for the complex design of the survey, as recommended by CDC. Like the Census data, the CDC data do not indicate an immigrant's legal status.

Figure 4. The 2002 data about community health centers are from a special nationwide survey of patients conducted by the Health Services and Resource Administration. Administrative data for 2002 and 2007 are drawn from the Uniform Data System, which includes administrative data reported by all federally qualified health centers nationwide. The administrative data available from the Uniform Data System have less information about the characteristics of patients than those available from the special 2002 survey.