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Toward Equity and Access: Removing Legal Barriers To Health Insurance Coverage for Immigrants

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For nearly two decades, federal and state policies have piled atop one another to create barriers to health insurance coverage for millions of women, men and children residing in the United States with varying immigration statuses. These coverage restrictions foster harmful disparities in access to health care services generally, and to sexual and reproductive health services in particular. Inequitable access to coverage jeopardizes the health and well-being of immigrant women, families and communities into the next generation, and compromises the public health of the nation as a whole.

Following the 2012 elections, immigration reform has been back on the federal policy agenda, which presents a needed opportunity to raise awareness of and ultimately remove restrictions on immigrants' access to health coverage. Yet, those who hope for more equity for all individuals and families in the United States have cause to be wary; past attempts at bipartisan immigration reform have failed and left coverage gaps in place. Immigrants' health coverage needs were inadequately addressed in the landmark 2010 Patient Protection and Affordable Care Act (ACA). And millions of young immigrants newly eligible to lawfully reside in the United States as a result of a 2012 program unilaterally established by the Obama administration were denied most forms of health coverage under subsequent regulations. It is because of such past failings, however, that the best health and economic interests of immigrant women and their families—and the country they are part of—must be revisited.

A Patchwork of Policies

Since the mid-1990s, mounting anti-immigrant sentiment has left not only undocumented immigrants, but also recent, lawfully present immigrants with multiple barriers to and few options in accessing basic health coverage and services, including sexual and reproductive health care.

Prior to 1996, lawfully residing immigrants in the United States had the same eligibility as citizens for means-tested benefit programs under federal law. But, with the enactment of the Personal Responsibility and Work Opportunity Reconciliation Act, or "welfare reform," only immigrants who were lawfully residing before August 1996 maintained that eligibility. Most who immigrated after 1996 were (and still are) deemed ineligible for the first five years during which they have lawful status. Among the most important programs restricted to immigrants under the "five-year ban" is Medicaid—the country's largest insurer of low-income individuals and families, and a crucial source of coverage for sexual and reproductive health services. Immigrant children (including teenagers) who have been lawfully present in the United States for fewer than five years were similarly denied coverage through the closely related Children's Health Insurance Program (CHIP), implemented the following year.

Medicaid does pay for services provided in emergency situations, including labor and delivery, to people regardless of immigration status. Beyond that, limited exceptions to the five-year ban were eventually made for pregnant women and children. The first of two exceptions for pregnant women was a 2002 rule issued by the Bush ad-

ministration that allows states to provide prenatal care to low-income immigrant women—both lawfully present and undocumented—by granting CHIP eligibility to their fetuses (see "New SCHIP Prenatal Care Rule Advances Fetal Rights at Low-Income Women's Expense," December 2002). As of January 2013, 15 states had taken up this coverage option (see table).[1,2] Subsequently, when the 2009 Children's Health Insurance Program Reauthorization Act (CHIPRA) was enacted, it authorized states to waive the five-year ban for immigrant pregnant women (in their own right, as opposed to via their fetuses) and immigrant children otherwise eligible for Medicaid or CHIP. As of January 2013, 20 states offer this coverage to pregnant women, and 25 to children.[1]

Meanwhile, in 2006, Congress passed a requirement that nearly all citizens provide detailed documentation of their citizenship to enroll in or renew Medicaid coverage. (Noncitizen immigrants eligible for Medicaid were already required to provide documentation of their lawful status.) A tiered list of documentation was prescribed, with passports topping the list, even though many low-income individuals do not possess one; providing a birth certificate along with a driver's license or similar photo identification qualified as second-tier documentation (see "The Impact of Anti-Immigrant Policy on Publicly Subsidized Reproductive Health Care," Winter 2007). This cumbersome policy led to delays and declines in coverage and care among qualified citizens, as well as increased government costs for its implementation, and in recent years, the burden has been somewhat eased.[3] For example, CHIPRA gave states the option of employing electronic databases to verify eligibility prior to burdening individuals. Expanding on that successful provision, state agencies and health insurance exchanges, beginning in 2014 under the ACA, will be required to utilize data from electronic databases before requiring individuals to provide documentation to verify their eligibility for public or private coverage.

Beyond alleviating the citizenship documentation burden, however, health care reform was largely a missed opportunity to put right so much of what had gone wrong regarding immigrants'

EXCEPTIONS TO THE FIVE-YEAR BAN

	% of population who are immigrants	Federally funded coverage expansions		
		Lawfully residing children without 5-year wait	Lawfully residing pregnant women without 5-year wait	Pregnant women regardless of status (fetus option)
U.S. TOTAL	**13.0**	**25**	**20**	**15**
Alabama	3.4			
Alaska	7.1			
Arizona	13.4			
Arkansas	4.4			X
California	27.0	X	X	X
Colorado	9.7		X	
Connecticut	13.4	X	X	
Delaware	8.4	X	X	
Dist. of Columbia	13.5	X	X	
Florida	19.4			
Georgia	9.6			
Hawaii	17.9	X	X	
Idaho	6.0			
Illinois	14.0	X		X
Indiana	4.7			
Iowa	4.4	X		
Kansas	6.9			
Kentucky	3.2			
Louisiana	3.8			X
Maine	3.2	X	X	
Maryland	13.9	X	X	
Massachusetts	14.9	X	X	X
Michigan	6.1			X
Minnesota	7.3	X	X	X
Mississippi	2.2			
Missouri	4.0			
Montana	2.0	X		
Nebraska	6.3	X	X	X
Nevada	19.2			
New Hampshire	5.6			
New Jersey	21.5	X	X	
New Mexico	10.1	X	X	
New York	22.2	X	X	
North Carolina	7.3	X	X	
North Dakota	2.4			
Ohio	4.0			
Oklahoma	5.5			X
Oregon	9.8	X		X
Pennsylvania	5.9	X	X	
Rhode Island	13.5	X		X
South Carolina	4.7			
South Dakota	2.7			
Tennessee	4.8			X
Texas	16.4	X		X
Utah	8.4			
Vermont	3.9	X	X	
Virginia	11.1	X	X	
Washington	13.3	X	X	X
West Virginia	1.3			
Wisconsin	4.7	X	X	X
Wyoming	3.2			

Notes: Immigrant population estimates are from 2011 and include naturalized citizens, lawful permanent residents, certain legal nonimmigrants (e.g., persons on student or work visas), those admitted under refugee or asylee status, and undocumented immigrants. States can use Medicaid and CHIP funds to cover lawfully residing children and pregnant women, regardless of their date of entry, and can use CHIP funds to cover prenatal care, labor and delivery for a pregnant woman, regardless of legal status, by covering her fetus. Coverage policies are as of January 2013. *Sources:* references 1 and 2.

access to health coverage and care. Despite the initial intentions of some policymakers that immigrants' health insurance and health care needs would be addressed, the coverage benefits of the ACA as enacted are disproportionately inaccessible to immigrants. Aside from the state options to cover lawfully present children and pregnant women discussed above, the five-year Medicaid ban remains in effect. In a kind of concession, the ACA does enable immigrants who are ineligible for Medicaid due to the five-year ban to purchase private coverage through the insurance exchanges that will become operational in 2014, and to receive subsidies to make this coverage affordable. The ACA, however, not only makes undocumented immigrants ineligible for subsidies, but also prohibits them from purchasing coverage through exchanges—even at full cost.

Finally, in 2012, the president established the Deferred Action for Childhood Arrivals (DACA) program, which although an important step forward in its own right, was a bitter disappointment for advocates of immigrants' health coverage and service access. The program allows for previously undocumented young people (ages 15–30) who immigrated as children with their families and who are engaged in school or work to remain in the United States for renewable two-year periods. But unlike other lawfully present immigrants, young people granted DACA status are barred from nearly every form of public and private health coverage. DACA grantees are expressly carved out of the population of lawfully present immigrant children and pregnant women whom states may cover under Medicaid or CHIP through the 2009 CHIPRA option (see above). And under current rules, the years individuals live in the United States with DACA status do not count toward their five-year path to Medicaid eligibility. Furthermore, those with DACA status are ineligible to purchase private coverage on the health insurance exchanges, with or without the federal subsidies.

In short, despite now being lawfully present, those with DACA status have essentially the same coverage options as the estimated 11.1 million undocumented immigrants residing in the United States: nearly none.[4] Ineligible for Medicaid and CHIP, low-income young people with DACA status and undocumented immigrants can obtain Medicaid coverage only if they are pregnant and living in a state with the 2002 CHIP option, or if they live in a state or locality that uses entirely nonfederal funds to cover health services usually under Medicaid to individuals regardless of immigration status. When it comes to private coverage options, these populations will only be allowed to obtain coverage outside the exchanges.

The Case for Coverage

As a result of this patchwork of policies, millions of immigrant women and their families who live, go to school and work in communities all around the country are effectively blocked from obtaining health insurance. This disparity in coverage hinders immigrants' ability to obtain health care, including sexual and reproductive health services, which puts them at disproportionately high risk of negative health outcomes.

The gaps in immigrants' health coverage are great. Even though they are more likely than the native-born to participate in the U.S. workforce, immigrants are overrepresented in low-wage jobs that are unlikely to offer employer-sponsored health coverage.[5] This, along with existing policy barriers to public and private insurance options, contributes to noncitizen immigrants being much more likely than native-born or naturalized citizens to be uninsured. Among women of reproductive age (15–44), 45% of the 6.6 million noncitizen immigrants are uninsured, compared with 24% of naturalized citizen immigrants and 18% of U.S.-born women (see chart).[6] Among poor reproductive-age women (a group in which immigrant women are disproportionately represented), 60% percent of noncitizen immigrant women lack health insurance—nearly twice the proportion of U.S.-born women. And only 27% of poor immigrant women of reproductive age have Medicaid coverage, compared with 44% of those who are U.S. born.

Although there is limited evidence specific to immigrant women's use of sexual and reproductive health services, lack of insurance is generally associated with a reduced use of health services, especially among low-income women.[7] Thus, it is

unsurprising that according to at least one recent report, immigrant women's health service utilization is constrained by their lack of insurance coverage and the high out-of-pocket costs they confront as a result.[8] Yet, immigrant women—especially those who are undocumented—have higher birth rates than native-born women, and so are more likely to need comprehensive maternal care.[9,10] Immigrant women are also particularly likely to be young, low-income and women of color—all demographic characteristics linked to particularly high risk of negative sexual and reproductive health outcomes, namely unintended pregnancy and STIs.[7,10-12]

Comprehensive Maternity Care

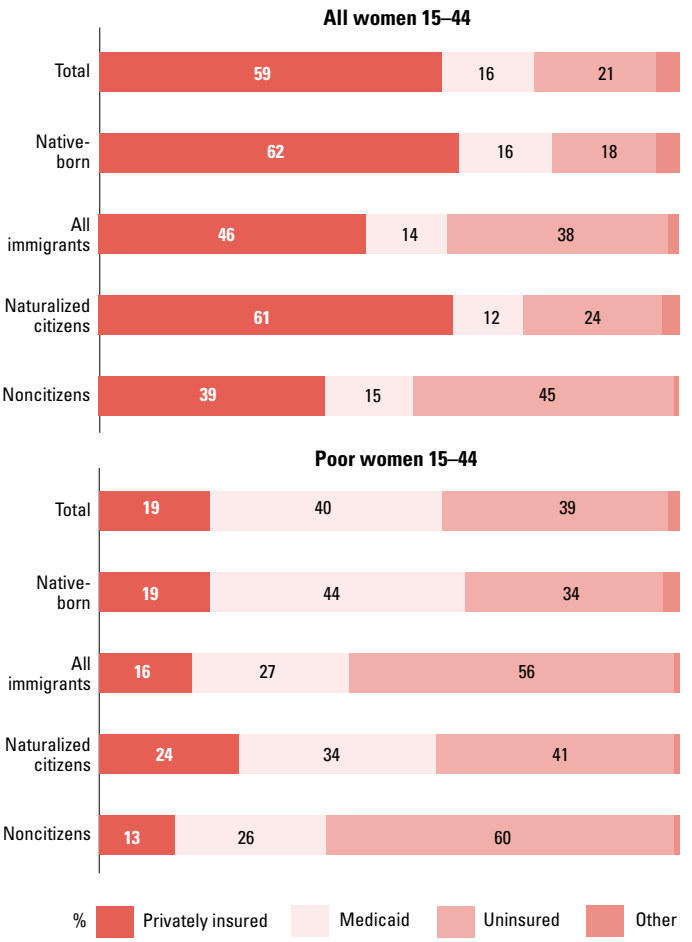
The widely recognized positive benefits of appropriate preconception, prenatal and postpartum care include better chances of full-term pregnancies and healthy birth weights and a decreased likelihood of long-term health complications for mothers and infants.[13] Prenatal care is particularly beneficial among young and low-income women, groups that are particularly likely to be uninsured.[14,15] Indeed, the ACA takes numerous steps to address these issues by expanding coverage generally and specifically guaranteeing coverage for a broad package of maternity care services (see "The Potential of Health Care Reform to Improve Pregnancy-Related Services and Outcomes," Summer 2010).

Yet, millions of immigrant women remain ineligible for comprehensive maternity coverage. And while what limited evidence there is suggests immigrant women have relatively healthy pregnancies,[16,17] their need for comprehensive maternity care is no different than U.S.-born women's. This is especially true as children of immigrants comprise ever-larger proportions of the overall U.S. population: Although their birth rates have declined consistent with, even driving, broader U.S. trends, immigrant women continue to have higher birthrates than native-born women.[10,18] In 2008, an estimated 8% of the babies born in the United States (340,000)—all of whom are automatically citizens—had undocumented parents, comprising a disproportionately large share of the newborn population.[9] Given these statistics, accessible comprehensive maternity coverage could advance long-term health outcomes among immigrant women and their children, reducing systemic health disparities with each new generation of Americans.

Coverage obstacles to immigrant women's affordable access to prenatal care are also financially short-sighted. An Institute of Medicine committee estimated that every $1 invested in preventive prenatal care would save more than $3 by reducing the number of low-birth-weight infants and the costs associated with their care.[19] Additionally, in a 2013 analysis, annual Medicaid emergency expenditures were estimated at $2 billion.[20] The

COVERAGE GAPS

The 6.6 million women of reproductive age who are not U.S. citizens are particularly likely to be uninsured.



Notes: 2011 data. Poor women are those in families with incomes under the federal poverty level ($19,090 for a family of three in 2011). Data include some information on undocumented immigrants, although that information is generally acknowledged to be a considerable undercount of that population group. *Source:* reference 6.

majority of those were for labor and delivery care for immigrant women in emergency rooms.[21] In sum, barriers to immigrant women's ability to obtain health insurance are putting the long-term health of these mothers and their infants at risk, and creating inefficiencies in public expenditures.

Contraceptive Services and Supplies

Effective contraception helps women to avoid unintended pregnancy and the adverse maternal and child health outcomes associated with unplanned births.[13] Women's ability to plan and space their children has also been linked to advanced educational and employment opportunities and pursuits, and to the enhanced well-being of families (related article, page 8). Yet, cost is one important factor that interferes with women's use of the most effective contraceptive methods. Eliminating cost-sharing for the full range of methods can help them overcome this barrier.

Despite the fact that contraceptive coverage without cost-sharing has long been available to women enrolled in Medicaid, and will increasingly be so in private insurance under the coverage advances of the ACA, millions of immigrant women are cut off from those options. As a result, they may lack access to the full range of contraceptive options; the limited evidence available specific to immigrant women suggests they are less likely to use preventive reproductive health services, including contraception.[8] This is particularly problematic as women of color and low-income women are disproportionately affected by unintended pregnancies.[11] And, undocumented immigrants—including the nearly one million young people estimated to immediately qualify for DACA status—are particularly likely to be of reproductive age and Hispanic origin.[22-24]

The fiscal case for contraceptive coverage with no cost-sharing for all women—including immigrant women—is a strong one. Nationally, the public costs related to births resulting from unintended pregnancies were estimated at $11 billion in 2006;[25] the estimated cost to federal, state and local governments of teen childbearing in 2008 was also estimated to be nearly $11 billion.[26] These costs would be even higher in the absence of publicly subsidized family planning services.

Every public dollar invested in helping women avoid pregnancies they do not want saves about $4 in Medicaid expenditures otherwise needed for pregnancy-related care and one year of infant medical care.[27] In the private sector, contraceptive coverage is at least cost-neutral, if not cost-saving. For instance, the federal government, in its role as the nation's largest employer, reported no cost increases after requiring coverage of contraceptives for its employees in the late 1990s.[28] Further, not covering contraceptives has been estimated to cost employers approximately 15% more than providing such coverage.[29] Importantly, none of these estimates take into account the broader health, social or economic benefits to women and families that come with being able to time, space and prepare for pregnancies—crucial considerations for immigrant women's full and productive integration into U.S. society.

Preventive Services

Finally, there are a number of other preventive sexual and reproductive health services important for all women of reproductive age, such as regular well-woman visits, STI testing and screening for reproductive health cancers. Without adequate health coverage, these preventive services can be costly and out of reach, particularly to teenagers and young adults with little disposable income.

As a group, the disproportionately young, low-income immigrant population is at heightened risk for STIs, notably HPV. According to a February 2013 report from the CDC, half of all new STI cases occur among 15–24-year-olds, and HPV accounts for 14 million of the 20 million new STI cases each year.[12] HPV is a particularly salient issue among immigrant women: Left unchecked, certain strains of HPV can occasionally lead to cervical cancer, which disproportionately afflicts and causes the deaths of foreign-born women, particularly those who are Latina and women in certain Asian communities.[30] This phenomenon is likely due in large part to the fact that many of these women go without timely Pap tests and screenings, which in turn stems from financial, cultural and linguistic barriers.[8]

Not extending coverage for STI testing to low-income immigrants is also fiscally questionable.

There are no cost estimates specific to immigrants, but the most recent CDC analysis estimates that $16 billion is spent in the United States each year on the direct medical costs of STIs; the majority is devoted to long-term treatment and care of HIV and of HPV and its resultant cancers.[12]

A Need for Action

In his 2013 State of the Union address, President Obama called for "comprehensive" immigration reform, and a draft of the administration's proposal was released shortly thereafter. Meanwhile, multiple congressional groupings—most notably the Senate "Gang of Eight"—have released their own bipartisan principles. Despite major differences over border security and whether reform should include a path to citizenship, there does seem to be an emerging consensus: If this federal legislation is enacted, it will likely grant some form of provisional status to undocumented immigrants currently living in the United States.

With that status, whatever it may be, should come access to affordable public and private health insurance options, and the increased access to sexual and reproductive health services that insurance coverage makes possible. Indeed, this principle already has broad public support: Most Americans believe upon obtaining provisional status, immigrants should be able to access Medicaid (63%) and subsidies to affordably buy insurance on the exchanges (59%).[31]

This principle should apply not only those with this provisional status, but also to those with DACA status and all other immigrant individuals and families lawfully present in the United States. They should all be eligible for Medicaid and CHIP without the five-year ban or any other waiting periods. Enabling immigrants—based solely on their income—to access Medicaid coverage instead of the more costly coverage available on the exchanges is sound health policy that also has the potential to save federal dollars. That said, private coverage should be made equally accessible. All lawfully present immigrant individuals and families—again including those with DACA status and those with any newly established status resulting from immigration reform—should be able to purchase coverage through the health insurance exchanges and to receive income-based subsidies to make this coverage affordable.

The recent immigration reform discussions to date continue a long-term trend of giving short shrift to the legitimate health insurance and health care needs of our nation's immigrants, including coverage and care related to sexual and reproductive health. The outcome of the immigration reform debate is uncertain and the stakes are high for immigrants and U.S.-born citizens alike, but the time has come to define "comprehensive" reform to include more than issues of border security and citizenship. The human needs—including health care—of immigrant women, men and children must also be embraced. The case for doing so—in the health and economic interests of immigrant families and in the shared public health and fiscal interest of the country—is compelling. **www.guttmacher.org**

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