

HEALTH CARE FOR IMMIGRANT FAMILIES

CURRENT POLICIES AND ISSUES



YOUNG CHILDREN OF IMMIGRANTS: RESEARCH FINDINGS AND POLICY CHOICES

LEIGHTON KU
MARIELLEN JEWERS

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MIGRATION POLICY INSTITUTE

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Leighton Ku and Mariellen Jewers
George Washington University

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To access other papers produced for the symposium, please visit: www.migrationpolicy.org/integration.

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Executive Summary

The prospect that Congress may act on a comprehensive immigration reform bill provides an important opportunity to assess how the current American system addresses the health needs of immigrants in the United States.

Low-income immigrants are much more likely to lack health insurance than similarly poor native-born citizens, because of shortfalls in their access to both public insurance, such as Medicaid and the Children's Health Insurance Program, as well as private job-based health insurance. The 1996 welfare reform law restricted access for recent lawful permanent residents (LPRs) for public insurance; meanwhile, unauthorized immigrants remain ineligible. Immigrants are also less likely to be offered job-based insurance, at least in part because they often work in sectors — such as agriculture, food service, and construction — that have low insurance coverage.

As a result, immigrants also have less access to health care services and are less likely to see a doctor or even visit an emergency room. In addition to problems affording care among the many who are uninsured, immigrants often encounter problems finding health care providers who can communicate in their language. Safety-net clinics, such as nonprofit community health centers, help provide access even to the poor and uninsured, but have their limits. There have been a number of efforts to help assure that those who lack English proficiency can get language assistance, such as interpreters, but there is little information about whether these efforts are making gains.

Prospects are improving, however. A 2009 law allows states to eliminate the five-year waiting period for LPR children and pregnant women, and a large number of states have expanded coverage for these groups. The *Affordable Care Act* will also help many legal immigrants by expanding Medicaid coverage and offering better opportunities to buy private health insurance in new health insurance exchanges, with income-related tax subsidies to help make them more affordable.

Low-income immigrants are much more likely to lack health insurance than similarly poor native-born citizens.

It is too early to assess how comprehensive immigration reform bills may affect health care access for immigrants, including those who may be on a path toward citizenship. The federal health reform law has been — and remains — polarizing, and immigration reform is likely to be controversial, so the combination of issues could be vexing. Initial legislative proposals have shown reluctance to provide access to health insurance coverage to unauthorized immigrants who gain provisional status on the path toward citizenship. Even so, there are a variety of ways to help improve health access for needy immigrants, particularly those who have been legally admitted. These include encouraging states to take up the option to expand Medicaid and to adopt options to eliminate waiting periods for legal immigrant children and pregnant women. Supporting the health care safety net by, for example, expanding community health centers will help assure access, even for those who remain uninsured. Efforts to continue to increase language access — and to measure the extent to which these services are being provided — will both help improve access to care as well as improve the quality of health care received.



I. Introduction

Of all the forms of inequality, injustice in health care is the most shocking and inhumane.

Rev. Martin Luther King, Jr., 1966

Many believe that quality health care is a fundamental human right and an antidote to the health care disparities that afflict our nation. Even though health care reform is arguably one of the most important social policies in the United States since the 1960s, it has become a polarizing topic. As those who are following the current immigration reform debate realize, immigration policy and the rights of immigrants in the United States are also contentious. Put together, these two topics can be explosive. Many people remember the outburst by US Representative Joe Wilson of South Carolina when he cried out “You lie!” after President Obama told a joint session of Congress that his health reform proposal would not apply to unauthorized immigrants.¹

The *Patient Protection and Affordable Care Act* (ACA) was narrowly enacted and has continued to be one of the most hotly argued government policies in recent years. Since the 2012 elections, the nation has begun another national dialogue — on immigration reform. In May 2013, the Senate Judiciary Committee approved an immigration reform bill crafted by a bipartisan group of senators, the *Border Security, Economic Opportunity, and Immigration Modernization Act of 2013*, and sent it on to the full Senate for its consideration in June. Also during May, the House of Representatives voted yet again to repeal the *Affordable Care Act*, knowing that repeal would not be accepted by the Senate or president. How Congress and the nation ultimately will address both concerns remains to be seen.

Regardless of the controversies surrounding health care policy and immigration, the United States has made important progress in improving immigrants’ health care, particularly for children in immigrant families. Though much remains to be done, three areas of progress stand out:

1. Health insurance coverage for members of immigrant families, especially those who are noncitizens, has been improved.
2. Access to health care services has been increased.
3. Language and cultural barriers to quality care have been reduced.

Regardless of the controversies surrounding health care policy and immigration, the United States has made important progress in improving immigrants’ health care.

Health insurance, health care access, and language and cultural barriers are distinct but intrinsically linked. Being insured is one of the strongest determinants of getting timely health care. Yet health insurance coverage is not synonymous with health care access. Likewise, health care access does not guarantee that people will use services. For example, if patients know they will have difficulty explaining their medical needs or problems to a doctor or nurse, they are less willing to seek care.

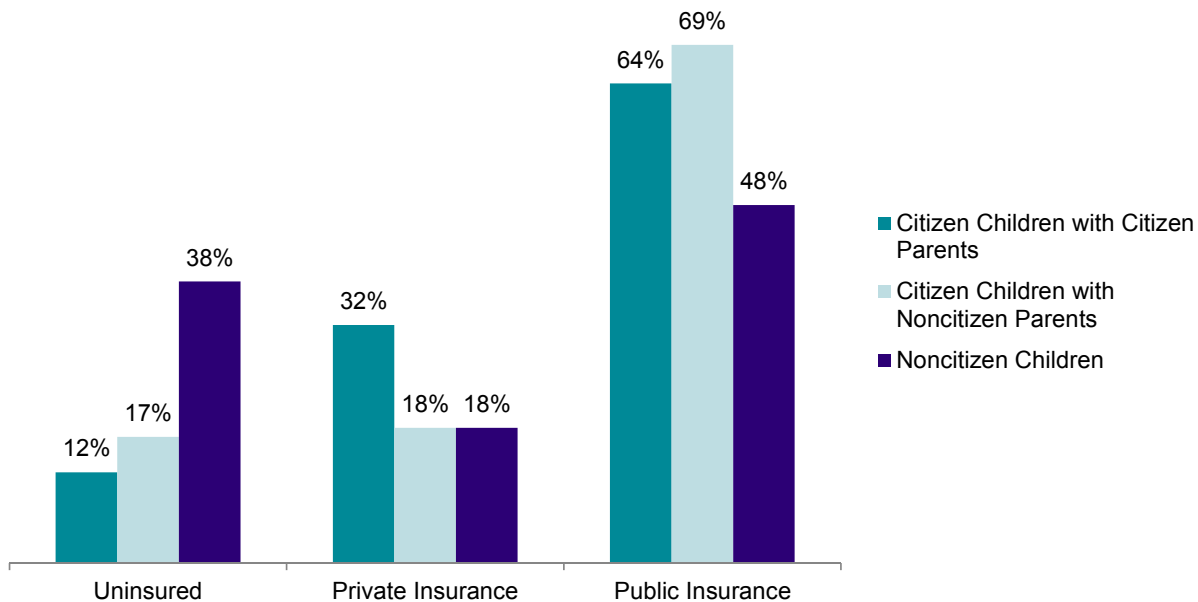
¹ Carl Hulse, “In Lawmaker’s Outburst, a Rare Breach of Protocol,” *New York Times*, September 9, 2009, www.nytimes.com/2009/09/10/us/politics/10wilson.html.



II. Health Insurance Coverage in the United States

Perhaps the most visible and frequently debated issue in health policy is health insurance coverage. For the majority of Americans, health insurance coverage is associated with their jobs (i.e., it is sponsored by employers or unions). Private, primarily job-based insurance covers 55 percent of the US population.² Next in importance is public health insurance, such as Medicare for the elderly or Medicaid or the Children's Health Insurance Program (CHIP) for low-income families and children. However, citizenship and immigration status affect the extent to which immigrants and their families can obtain health insurance and whether they remain uninsured. Overall, almost half (44 percent) of noncitizen immigrants in the United States are uninsured, compared to 13 percent of native-born citizens, according to Census data for 2011.³

Figure 1. Health Insurance Coverage for Low-Income Children (Ages 18 and Under), United States, 2011



Note: Low-income children are those with family incomes below 200 percent of the federal poverty level. Percentages may not add up to 100 due to overlaps in public and private coverage and rounding.

Source: George Washington University Department of Health Policy analysis of data from the US Current Population Survey (CPS), March Annual Social and Economic Supplement, 2012.

The following analyses focus on low-income people — those with incomes below 200 percent of the federal poverty level (FPL), who are more likely to be uninsured and to lack access to health care than those of higher income. Low-income children and adults who are noncitizen immigrants are much more likely to be uninsured than low-income citizens.⁴ As seen in Figure 1, low-income children with noncitizen

2 Carmen DeNevas-Walt, Bernadette D. Proctor, and Jessica C. Smith, "Income, Poverty, and Health Insurance Coverage in the United States: 2011" (Current Population Reports, P60-243, US Census Bureau, US Government Printing Office, Washington, DC, 2012), www.census.gov/prod/2012pubs/p60-243.pdf.

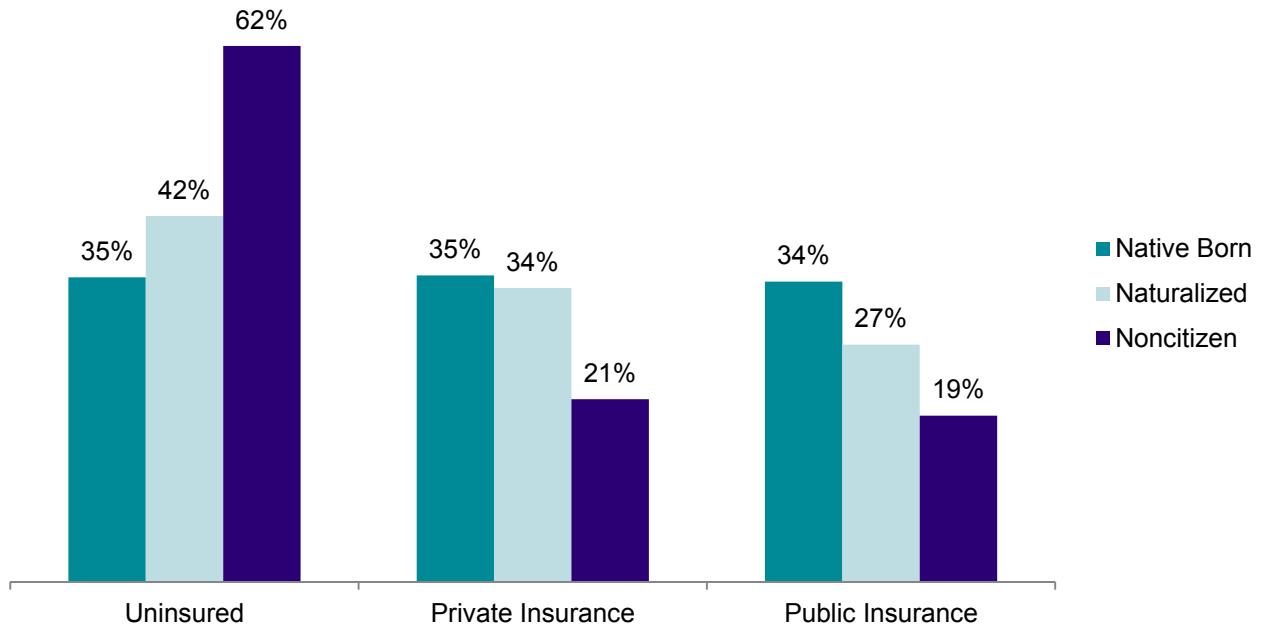
3 Analysis of data from the US Current Population Survey (CPS), March Annual Social and Economic Supplement, 2012, by the Department of Health Policy, George Washington University, Washington, DC.

4 Data in Figures 1 and 2 are based on the authors' analyses of the Census Bureau's March 2012 CPS, Annual Social and Economic Supplement. This CPS supplement is a nationally representative survey of noninstitutionalized persons, and records individuals' health insurance status in 2011. It is the most commonly used data source for information about health insurance coverage in the United States. The survey identifies foreign-born status and citizenship, but does not identify legal status of immigrants. Brian Bruen of George Washington University's Department of Health Policy helped develop the analytic files that we analyzed.



parents are more likely to be uninsured than those with citizen parents. The risks are particularly high for children who are themselves noncitizens:⁵ among low-income children with noncitizen parents, the risk of not having any insurance (public or private) is more than twice as high for noncitizen children (38 percent) than for citizen children (17 percent). The patterns for low-income adults ages 19 to 64 are similar (see Figure 2).⁶ Almost twice as many (62 percent) low-income noncitizen adults are uninsured as low-income citizen adults (35 percent).

Figure 2. Health Insurance Coverage for Low-Income Adults (Ages 19 to 64), United States, 2011



Notes: Low-income adults are those with family incomes below 200 percent of the federal poverty level. Percentages may not add up to 100 due to overlaps in public and private coverage and rounding. Adults ages 65 and over are excluded because the vast majority is eligible for public health insurance coverage through Medicare.

Source: George Washington University Department of Health Policy analysis of data from the US Current Population Survey (CPS), March Annual Social and Economic Supplement, 2012.

Low coverage of noncitizen adults is due in part to low coverage through their employers. To be sure, noncitizens are just as willing as citizens to pay for job-based insurance, but most simply do not have the opportunity to do so. Noncitizen workers are less likely than naturalized and US-born citizens to be offered job-based health insurance.⁷ About 40 percent of noncitizen workers are employed in service and construction industries, which have low rates of insurance offerings.

5 A citizen child with noncitizen parents is defined as a child (US born or naturalized) with one or more noncitizen parents. Most children in immigrant families are US born and therefore citizens, regardless of their parents' citizenship. Noncitizen children are classified based on their own citizenship, but over 90 percent have noncitizen parents. Children with citizen parents include children with naturalized citizen parents and children with US-born citizen parents.

6 Adults ages 65 and over are excluded from this analysis because the vast majority is eligible for public health insurance coverage through Medicare.

7 Enrico Marcelli, "Comparisons of Insurance among Latinos in California 1999-2011," *Migraciones Internacionales* 2 (2004): 5-36; Richard E. Brown, Roberta Wyn, and Victoria Ojeda, *Access to Health Insurance and Health Care for Children in Immigrant Families* (Los Angeles, CA: University of California, Los Angeles Center for Health Policy Research, 1999).



Many others work in agriculture or small businesses, which often do not offer health insurance to their employees.⁸ Thus, a large number of immigrant workers find that job-based health insurance is unavailable to them. If noncitizen parents are unable to get job-based insurance, as often occurs, their children are also likely to be uninsured. Among low-income families, only 18 percent of children with noncitizen parents (regardless of whether the children are citizens or noncitizens themselves) have private insurance, a level about half that of children with citizen parents (32 percent).

Both because of the lack of available job-based health insurance and because immigrant families tend to have lower incomes than the average American family, public health insurance — particularly Medicaid and CHIP — assumes greater importance for children with immigrant parents. Yet, immigrants are constrained from gaining access to these programs, because of eligibility restrictions placed on noncitizens. Since 1996, adults who are lawful permanent residents (LPRs) or “green card” holders have been generally ineligible for Medicaid and CHIP during their first five years in permanent resident status, no matter how poor they are.^{9, 10} One of the first laws signed by President Obama in 2009 was the *CHIP Reauthorization Act*, which included a provision — known as the *Immigrant Children’s Health Improvement Act* (ICHIA) — that gave states the option to restore coverage to LPR children and pregnant women without a five-year waiting period. Although ICHIA had bipartisan support, it took more than a decade of advocacy and repeated efforts to secure its enactment into law.

If noncitizen parents are unable to get job-based insurance, as often occurs, their children are also likely to be uninsured.

ICHIA is optional for states; they are not required to cover LPR children or pregnant women during the five-year waiting period. However, states’ responses to ICHIA’s option to cover these LPR children and pregnant women have been encouraging. As of early 2012, 24 states (including the District of Columbia) had adopted the option to extend Medicaid coverage to LPR children during the five-year waiting period, and 16 states (including the District of Columbia) had opted to extend coverage to LPR pregnant women during this period.¹¹ Many of these states previously covered LPR children or pregnant women before 2009 during the waiting period, but had used only state funds to support their coverage. In these states, the adoption of ICHIA restored federal matching funds for Medicaid coverage of these LPR children and pregnant women, but did not increase the number with Medicaid coverage. What is noteworthy is that nine very different and diverse states (Illinois, Iowa, Montana, New Mexico, North Carolina, Oregon, Texas, Vermont, and Washington) opted to expand Medicaid coverage to LPR children during the five-year waiting period, even though they had not previously done so using their own funding. Despite the recession and a desperate budget environment for states, these states were willing to pay the state

8 Alison Siskin, *Noncitizen Health Insurance Coverage Use of Select Safety-Net Providers* (Washington, DC: Congressional Research Service, 2009), www.ilw.com/immigrationdaily/news/2011,0316-crs.pdf.

9 Lawful permanent residents (LPRs) are those admitted permanently through legal immigration channels, and do not include those with temporary visas such as students and temporary workers.

10 All people who meet income and categorical requirements for Medicaid (e.g., poor children, parents, the elderly, disabled, etc.) are eligible for Medicaid coverage of emergency medical care, including childbirth, regardless of citizenship status. In large measure, this policy is intended to help support hospital emergency departments that are required to screen and stabilize all individuals who come with emergency conditions, regardless of insurance status, under the *Emergency Medical Treatment and Active Labor Act* (EMTALA). EMTALA ensures that uninsured people, including immigrants, can get emergency care, while emergency Medicaid provides reimbursement.

11 Georgetown University Health Policy Institute Center for Children and Families, “Coverage of Lawfully-Residing Immigrant Children and Pregnant Women without a 5-Year Waiting Period, as of February 2012,” <http://ccf.georgetown.edu/wp-content/uploads/2012/04/ICHIA.pdf>.



Medicaid match to extend coverage to these immigrant children.¹² The nine states demonstrate that incremental progress can be made on a bipartisan basis even during very tough fiscal times. In other states, discussions to extend Medicaid coverage to these groups of LPRs are currently under way.

Because Medicaid and CHIP do not restrict eligibility for citizens, about two-thirds of low-income citizen children in both citizen families (64 percent) and noncitizen families (69 percent) have public insurance, while slightly less than half (48 percent) of noncitizen children are publicly covered. The level of public coverage for noncitizen children is bolstered because so many states have been willing to cover LPR children using ICHIA (or state funds before that). Unfortunately, the same progress has not been made in increasing public insurance coverage for low-income noncitizen adults. Medicaid eligibility is much more restrictive for adults than for children today, and there is no equivalent to the ICHIA option for adult LPRs with fewer than five years of permanent residency.

The Affordable Care Act. The ACA includes a number of changes that will improve the affordability of health insurance for millions of Americans, including those living in immigrant families, beginning in 2014. Unlike Medicaid and CHIP, ACA subsidies for private health insurance are available to all noncitizens who are “lawfully present” — including LPRs as well as those who have a temporary or provisional legal status. Under current law, ACA subsidies only exclude unauthorized immigrants.

The ACA’s subsidies would allow lawfully present immigrants, like citizens, to purchase health insurance in newly developed health insurance exchanges for individuals and small businesses, if they cannot otherwise obtain job-based or public insurance. Lawfully present immigrants and citizens with incomes between 100 and 400 percent of FPL will be eligible for federal tax credits to offset the cost of private insurance purchased through the exchanges. In addition, lawfully present immigrants with incomes below 100 percent of FPL will be eligible for the exchange and tax credits if they are ineligible for Medicaid, either because they are not LPRs (i.e., they have a temporary or provisional but not a permanent legal status), or if they are LPRs with fewer than five years of permanent residency. Since a principal barrier to health insurance coverage for immigrants is that they are not offered job-based health insurance, these new policies open much broader access to health coverage to lawfully present immigrants and their families, who will in theory be able to buy private coverage similar to what most privately insured Americans have already.

*Medicaid eligibility is much more restrictive for adults
than for children today.*

The current debate over immigration reform, however, suggests that the ACA subsidies may not be extended to those unauthorized immigrants who legalize but have only a provisional, and not a permanent, resident status. As currently outlined, the Senate and Obama administration proposals would grant unauthorized immigrants provisional status for a period of several years; during this time they would not be eligible for means-tested public benefits such as Medicaid and CHIP, nor would they be eligible for ACA subsidies. Whether a final immigration reform law extends eligibility for ACA subsidies to immigrants during the provisional period remains to be seen.

12 Commonwealth Institute for Fiscal Analysis, *Lessons from the Field: Expanding Access to Health Care for Immigrants in Virginia* (Richmond, VA: Commonwealth Institute for Fiscal Analysis, 2012).



The ACA will also extend Medicaid eligibility for nonelderly adults with incomes up to 133 percent of FPL in 2014. Currently, low-income parents' eligibility varies by state, but the median eligibility threshold is 70 percent of FPL, and the threshold is as low as 24 percent of FPL in some states.¹³ Low-income adults without dependent children are not eligible for Medicaid in most states. However, the Supreme Court's ruling in the landmark *NFIB v. Sebelius* case grants states the right to refuse to expand Medicaid to all adults with incomes below 133 percent of FPL. In states that expand coverage, large numbers of LPR adults with more than five years of permanent residency will gain coverage. Since low-income immigrant adults have such low rates of insurance coverage, this change constitutes a major expansion of coverage. However, we do not know which states will or will not expand Medicaid at this time. It seems likely that some major immigrant destinations (such as Texas, Florida, and Georgia) will not expand Medicaid, while others (such as California, New York, and Massachusetts) will.

Overall, immigrants have poorer access to medical care than the native born, even when they are insured.

Unauthorized immigrants will likely remain ineligible for public insurance coverage or even private insurance offered in the health insurance exchanges. In June 2012 the Obama administration announced a new Deferred Action for Childhood Arrivals (DACA) policy, which grants deferred action, or temporary permission to remain in the United States legally, for certain unauthorized young people who arrived in the country before the age of 16 and who have graduated from high school, are still in school, or have served in the military and do not have a criminal record. DACA youth will remain ineligible for insurance coverage under Medicaid, CHIP, and the ACA's subsidies and health insurance exchanges.¹⁴ As we note above, whether immigration reform will similarly exclude legalizing immigrants with provisional status from health coverage remains to be seen.

III. Access to Health Care

Having health insurance makes medical care more affordable and accessible. But many are able to access at least some health care, even if they are uninsured. There is a system of safety-net health care providers, such as nonprofit community health centers, charity hospitals, and public clinics and hospitals that deliver free- or sliding-scale care to those who lack insurance. Despite their limited resources, these facilities also serve insured patients, particularly Medicaid and Medicare patients, so they may have waiting lists, making it harder to get services at times.

Overall, immigrants have poorer access to medical care than the native born, even when they are insured. One way to measure health care access is to estimate the share of the population who has made at least one office-based medical visit — that is, a regular doctor's office visit — per year.¹⁵ Overall, 47 percent of

13 Kaiser Commission on Medicaid and the Uninsured, "Where are States Today? Medicaid and CHIP Eligibility Levels for Children and Non-Disabled Adults," March 28, 2013, <http://kff.org/medicaid/fact-sheet/where-are-states-today-medicaid-and-chip/>.

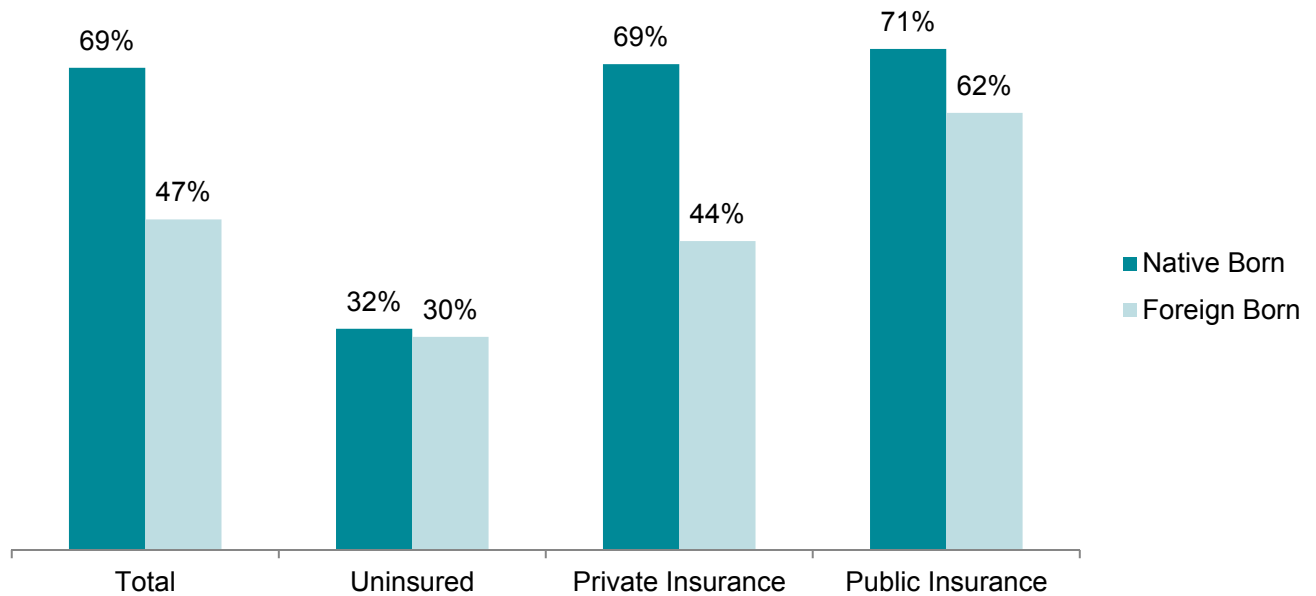
14 National Immigration Law Center (NILC), "Frequently Asked Questions: Exclusion of People Granted 'Deferred Action for Childhood Arrivals' from Affordable Health Care," November 26, 2012, www.nilc.org/acadacafaq.html.

15 Data presented in Figures 3 through 6 are based on the full-year consolidated file for the 2010 Medical Expenditure Panel Survey (MEPS), conducted by the Agency for Healthcare Research and Quality. MEPS is a nationally representative survey of health insurance coverage, utilization, and expenditures for noninstitutionalized persons. The MEPS data identify foreign-born persons, but do not identify their citizenship or legal status. Children of immigrants are classified based on their own nativity, as native-born or foreign-born children.



immigrant (i.e., foreign-born) children made a medical visit in 2010, compared to 69 percent of native-born children (see Figure 3). Native-born children with insurance were more than twice as likely to see a doctor as uninsured native-born children. Immigrant children with insurance were also more likely to see a doctor than uninsured immigrants, but insurance coverage did not yield as large an increase in access. Figure 4 shows comparable statistics for low-income adults. Immigrants have poorer access to office-based medical care than the native-born, and the disparities persist regardless of whether people have insurance or not.

Figure 3. Share of Low-Income Children (Ages 17 and Younger) with Any Office-Based Medical Visits in the Prior Year, 2010

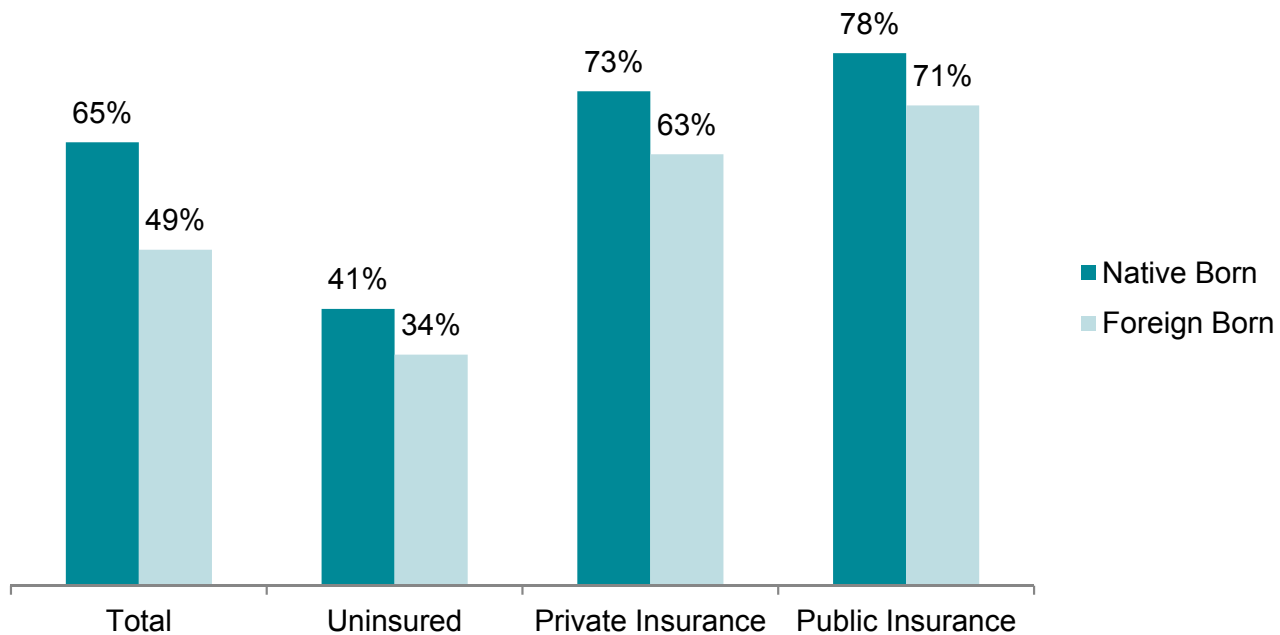


Note: Low-income children are those with family incomes below 200 percent of the federal poverty level. Percentages may not add up to 100 due to overlaps in public and private coverage and rounding.

Source: George Washington University Department of Health Policy analysis of data from the 2010 Medical Expenditure Panel Survey (MEPS).



Figure 4. Share of Low-Income Adults (Ages 18 to 64) Who Made an Office-Based Medical Visit in the Previous Year, 2010



Note: Low-income adults are those with family incomes below 200 percent of the federal poverty level. Percentages may not add up to 100 due to overlaps in public and private coverage and rounding. Adults ages 65 and over are excluded from the analysis because the vast majority is eligible for public health insurance coverage through Medicare.

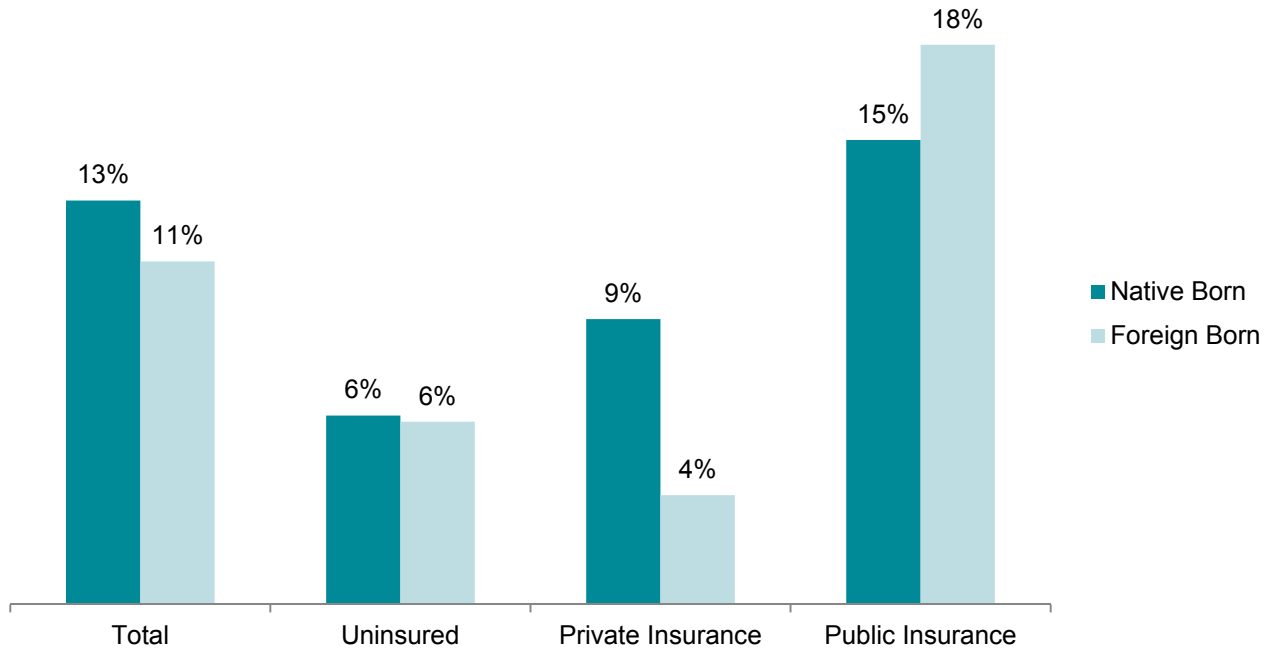
Source: George Washington University Department of Health Policy analysis of 2010 MEPS data.

It is commonly believed that uninsured immigrants overwhelm emergency rooms, perhaps in part because so many are uninsured and have problems securing care in doctors' offices. Data indicate that this is a myth, however, and that immigrants use emergency rooms more sparingly than the native born.¹⁶ Immigrant children were slightly less likely to use emergency rooms than native-born children overall, although they were slightly more likely to use them when publicly insured and less likely to use them when privately insured (see Figure 5). (It is worth remembering that Medicaid covers emergency-room services for noncitizen immigrant children in all states.) For adults, we see that immigrants were consistently less likely to use emergency rooms, regardless of whether they were uninsured or had private or public coverage (see Figure 6).

¹⁶ Comparable results have been found using other data sources. See Leighton Ku and Sheetal Matani, "Left Out: Immigrants' Access to Health Care and Insurance," *Health Affairs* 20, No. 1 (2001): 247–56.



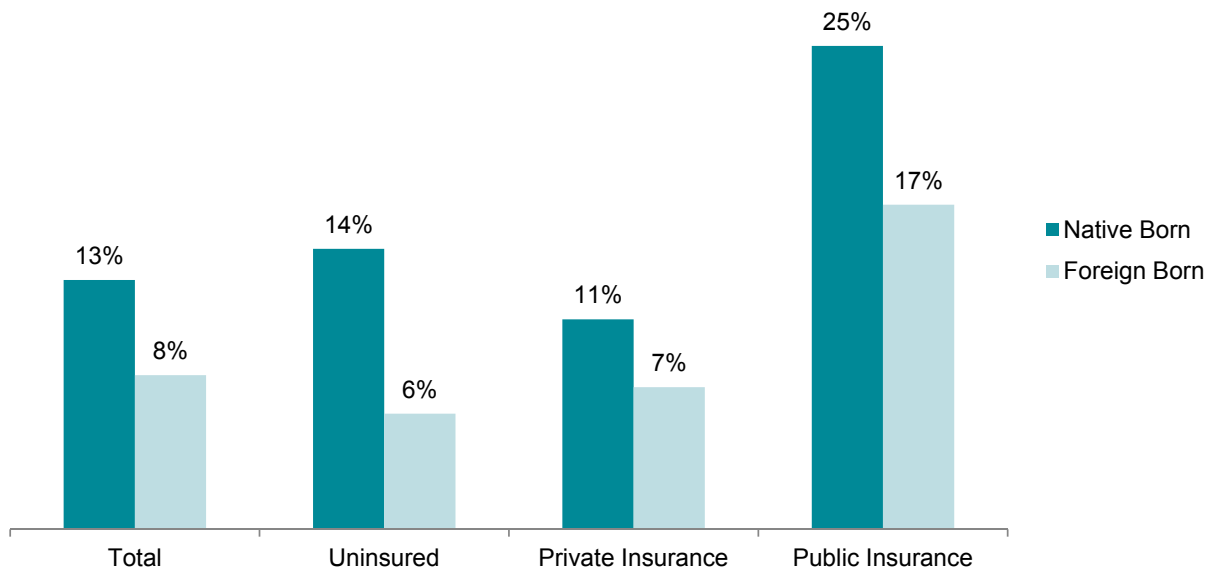
Figure 5. Share of Low-Income Children (Ages 17 and Under) with Any Emergency-Room Visits in the Prior Year, 2010



Notes: Low-income children are those with family incomes below 200 percent of the federal poverty level. Percentages may not add up to 100 due to overlaps in public and private coverage and rounding.

Source: George Washington University Department of Health Policy analysis of 2010 MEPS data.

Figure 6. Share of Low-Income Adults (Ages 18 to 64) with Any Emergency-Room Visits in the Prior Year, 2010



Notes: Low-income adults are those with family incomes below 200 percent of the federal poverty level. Percentages may not add up to 100 due to overlaps in public and private coverage and rounding. Adults ages 65 and over are excluded because the vast majority is eligible for public health insurance coverage through Medicare.

Source: George Washington University Department of Health Policy analysis of 2010 MEPS data.



Some may question these results because they are based on household surveys, and respondents may not be completely reliable. But administrative data, too, indicate that public beliefs about unauthorized, uninsured immigrants' use of emergency rooms are exaggerated. Several years ago the federal government established a special \$1 billion fund — called Section 1011 — to reimburse hospitals for uncompensated costs incurred by unauthorized immigrants for emergency care. Each year from 2005 to 2008, \$250 million was allotted for this purpose. To give a sense of perspective, total annual US emergency-room expenditures are about \$50 billion annually,¹⁷ and so Section 1011 funding represented about one-half of 1 percent of emergency-room expenses — hardly an overwhelming share. Many believed that the uncompensated care costs due to unauthorized immigrants were far larger and that Section 1011 funds would be rapidly depleted. In fact, as of the third quarter of fiscal year (FY) 2012 — four years after the \$1 billion appropriation was supposed to expire — \$54.6 million remained unused in the Section 1011 account, and hospitals in 22 states and the District of Columbia had still not fully spent their allotted funds.¹⁸

Insurance coverage does not, in and of itself, ensure access to care.

Why do immigrants have such limited health care access? Much of the reason is related to insurance coverage and financial access: when people — native-born or immigrant — have health insurance, out-of-pocket health care costs fall, and access becomes more affordable. But immigrants face other barriers, too.

- *Language barriers* limit access. If patients know they will have difficulty explaining their medical needs or problems to a doctor or nurse, they are less willing to seek care. About 30 percent of the foreign-born do not speak English or do not speak it well.¹⁹
- *Cultural differences* also play a role. The medical care system is organized differently in the United States than in immigrants' home countries, and managed care can be particularly difficult to navigate. Immigrants are less likely to have a primary physician or other, usual source of care than the native-born who have grown up in the United States' complicated system.
- Immigrants may have *different perceptions* of the need and appropriateness of medical care. The need for preventive care may be less familiar. In many countries, seeking help for mental health problems is stigmatized.
- Finally, *legal status* can be a concern. Unauthorized immigrants often worry that seeking care, particularly at a public facility, may lead to exposure of their unauthorized status and increase the risk of sanctions such as deportation. Even legal immigrants may worry that using benefits could jeopardize their legal status and perhaps make it harder to gain citizenship or permanent residency.

As mentioned before, insurance coverage does not, in and of itself, ensure access to care. There must also be health care providers who are willing to serve needy patients, whether they are insured or not. One particularly important federal initiative is the community health center program. Community

17 David Kashihara and Kelly Carper, "National Health Care Expenses in the U.S. Civilian Noninstitutionalized Population, 2009" (Medical Expenditure Panel Survey Brief #355, Agency for Healthcare Research and Quality, 2012), http://meps.ahrq.gov/data_files/publications/st355/stat355.pdf.

18 The Section 1011 payment history is available at www.novitas-solutions.com/section1011/program/paymenthistory.html.

19 Elizabeth M. Grieco, Yesenia D. Acosta, G. Patricia de la Cruz, Christine Gambino, Thomas Gryn, Luke J. Larsen, Edward N. Trevelyan, and Nathan P. Walters, "The Foreign-Born Population in the United States: 2010" (American Community Survey Reports ACS-19, Census Bureau, Washington, DC, 2012), www.census.gov/prod/2012pubs/acs-19.pdf.



health centers are nonprofit primary care clinics, designed to help medically underserved populations, including the poor, the uninsured, migrant workers, and the homeless. Health centers provide affordable primary health care — using sliding-scale fees — to help low-income uninsured patients, many of whom are immigrants. With support from both the Bush and Obama administrations and from state and local governments, the number of patients who get care at health centers has more than doubled over the past decade. Although health center data do not indicate how many patients are immigrants, they do report how many require language assistance because of limited English proficiency. About one-quarter of health center patients need language assistance, and that number rose from 4.3 million in 2007 to 4.7 million in 2011. Health centers take pride in serving multicultural communities and make special efforts to provide language assistance and to make their care culturally appropriate; the average health center employs two interpreters and uses language lines and other multilingual staff to help meet language needs.²⁰

The ACA set aside funds to help further expand community health centers and safety-net health care, particularly in communities where access is poor. While health centers have continued to grow since 2009, federal and state budget difficulties have meant that actual funding levels have not increased as rapidly as planned.

IV. Language Barriers

In health care, as in many other service areas, limited English proficiency can be a serious barrier for immigrants. It is self-evident that decent health care requires patients and clinicians to discuss health problems and how to address them. Studies confirm that communications problems lead to mutual misunderstandings and errors in diagnosis, treatment, and patient adherence.²¹ Moreover, immigrants are deterred from seeking care for themselves or their children if they are not sure their doctor will speak their language. Hispanic parents have cited language problems as the leading barrier to their children's health care.²² Language barriers affect immigrants regardless of legal or citizenship status; many immigrants who have lived in the United States for decades still have limited English skills and may face problems explaining and understanding complex and sensitive health issues.

*In health care, as in many other service areas,
limited English proficiency can be a serious barrier for immigrants.*

The Clinton administration established a federal policy that health care providers had to assure language assistance for patients with limited English proficiency as an extension of civil-rights laws prohibiting discrimination on the basis of national origin.²³ But the reality is that many patients with limited English are still unable to get sufficient language assistance from, e.g., bilingual clinicians or trained interpreters.

20 US Department of Health and Human Services, Health Resources and Services Administration, "National Data," <http://bphc.hrsa.gov/healthcenterdatastatistics/nationaldata/index.html>.

21 Glenn Flores, "The Impact of Medical Interpreter Services on the Quality of Health Care: A Systematic Review," *Medical Care Research and Review* 62 (2005): 255-99.

22 Glenn Flores, Milagros Abreu, Mary Anne Olivar, and Beth Kastner, "Access Barriers to Health Care for Latino Children," *Archives of Pediatrics and Adolescent Medicine* 152 (1998): 1119-25.

23 White House, Executive Office of the President, "Executive Order 13166, Improving Access to Services for Persons with Limited English Proficiency," August 11, 2000, www.lep.gov/13166/eo13166.html.



In part, this is because health insurance typically does not pay for interpretation services — so clinics, hospitals, pharmacies, nursing homes, and other facilities have little incentive to hire interpreters or to pay for other forms of assistance, such as language lines.²⁴ Equally problematic are the logistical challenges of arranging for interpreters, language lines, or other translation methods. Even among well-intentioned health care providers, making special arrangements for an interpreter or language line can delay or disrupt the normal flow of medical care, creating problems and barriers.

But these problems can be addressed over time and with concerted effort. It has been challenging for hospitals and clinics to address infection-control methods like ensuring adequate hand washing and immunization of health care workers, but careful attention to quality improvement is improving the situation. Effectively erasing language barriers to health care utilization will not only entail making language assistance a legal right, but also ensuring that there is funding to support related services. It will also require a broader educational campaign, raising awareness that language barriers pose a major health quality problem.

Gradual progress is being made. Organizations that establish health quality standards for accreditation, such as the Joint Commission and the National Committee for Quality Assurance, have established standards aimed at improving the availability of language assistance in hospitals, standards that may eventually spread to ambulatory care settings.²⁵ The ACA requires that health care records include information about patients' primary language, along with more commonly reported items such as gender and race/ethnicity, which should make it easier to plan for adequate language services and to monitor disparities in health care delivery that could be related to language barriers.

The ACA also requires the collection of data on primary language in Department of Health and Human Services (HHS)-funded surveys and initiatives. The law also supports efforts to help enroll persons with limited English proficiency in Medicaid and health insurance exchanges through simplified and translated enrollment materials and through the development of new programs to assist those applying for coverage in the new health insurance exchanges.

V. Immigration Reform and Health Care

As a result of the 2012 elections, there is renewed policy interest in immigration reform at the federal level. The last major effort at reform, which occurred during the Bush administration, failed to reach consensus despite strong support from leading politicians in both the Republican and Democratic parties. President Obama has voiced support for reform, but it remains unclear what can be done while Congress remains divided and sometimes bitterly partisan. Although the Supreme Court affirmed the constitutionality of most of the ACA, and most believe that it will remain the law of the land, it remains a policy that many Republicans at the national level would still like to repeal and that many still oppose at state levels. Initiatives that combine immigration and health reform could prove particularly controversial.

It is difficult to offer meaningful recommendations about immigration reform and health issues without knowing more about the general direction of plans for immigration reform and the framework for

²⁴ Leighton Ku and Glenn Flores, "Pay Now or Pay Later: Providing Interpreter Services in Health Care," *Health Affairs* 24, No. 2 (2005): 435-44.

²⁵ For example, the National Committee for Quality Assurance (NCQA), *Implementing Multicultural Health Care Standards: Ideas and Examples* (Washington, DC: NCQA, 2010), www.ncqa.org/portals/0/Publications/Implementing%20MHC%20Standards%20Ideas%20and%20Examples%2004%2029%2010.pdf; and the Joint Commission, *Patient-Centered Communication Standards for Hospitals* (Oakbrook Terrace, IL: Joint Commission, 2011), www.jointcommission.org/assets/1/18/r3%20report%20issue%201%202011.pdf.



congressional deliberation. That said, the outlines currently made public by the Obama administration and the US Senate suggest that unauthorized immigrants who gain a provisional status on the path to citizenship will not be eligible for ACA subsidies, and that eligibility will only be conferred after they obtain LPR status. But at the time of writing, final legislation has yet to emerge.

Regardless of the important issue of the exclusion of legalizing immigrants from health benefits and subsidies, there are areas where incremental progress can be continued:

A. **Health Insurance**

- If states decide to expand Medicaid, this will significantly improve insurance coverage for low-income adults, including many legal immigrants with more than five years of permanent residency. Some large immigrant destinations — e.g., California, New York, and Massachusetts — are expanding Medicaid to cover all LPRs regardless of their length of US residency. California and New York have the two largest immigrant populations in the country, so their decisions to expand Medicaid are certain to have broader implications for the country as a whole.
- Additionally, more states could adopt the ICHIA option to provide Medicaid to immigrant children and pregnant women with fewer than five years of permanent residency. ICHIA is a relatively inexpensive initiative, since most children in immigrant families are already native-born, and state adoption would be a positive signal to immigrants in states looking to demonstrate bipartisan support for immigrant communities.
- Strong and effective outreach and education to immigrant communities regarding health insurance exchanges to workers and the firms that employ them could improve understanding and increase health insurance coverage for legal immigrants and help allay concerns about verification requirements for citizen children with unauthorized parents.

B. **Health Care Access**

- It will remain important to assure that there is adequate funding to support safety-net providers, such as community health centers. Research in Massachusetts found that, after that state's health reform, safety-net providers became even more important because the newly insured turned to these facilities to get care.²⁶ Without an adequate supply of primary care providers, expansion of health insurance coverage will not be able to improve access to care.
- Some mistakenly believe that after health reform is implemented, the only remaining uninsured people will be unauthorized immigrants, which might erode political support for safety-net providers. In fact, about three-quarters of those who remain uninsured (and who need access to community health centers and other safety-net providers) will continue to be citizens and legal residents, and only a small minority will be unauthorized immigrants.²⁷

26 Leighton Ku, Emily Jones, Peter Shin, Fraser Rothenberg Byrne, and Sharon K. Long, "Safety-Net Providers after Health Care Reform: Lessons from Massachusetts," *Archives of Internal Medicine* 171, No. 15 (2011): 1379-84.

27 Congressional Budget Office (CBO), "Estimates for the Insurance Coverage Provisions of the Affordable Care Act Updated for the Recent Supreme Court Decision," July 24, 2012. www.cbo.gov/publication/43472.



C. Reducing Language Barriers

- Establishing policies to reimburse health care providers that provide language services would be extremely helpful. Medicare does not currently provide reimbursement for language services. If Medicare paid for language services, it seems likely that many private health insurance plans would follow suit. A number of state Medicaid programs pay for language services, and the 2009 *CHIP Reauthorization Act* offers matching funds for administrative costs for interpretation and translation services. However, the norm is that Medicaid does not cover these services. Thus, health care providers must pay for these services out of their own pockets, reducing their willingness to provide adequate language services.
- Further development of language-related quality standards and monitoring would also help. There are no routine surveys of the extent to which health care providers offer language assistance to patients with limited English proficiency. This makes it hard to know where gaps exist — and where they are being narrowed.
- While there are numerous efforts to improve quality in health care, there are also strong efforts to reduce health care costs; it is critical to ensure that an appropriate balance is being struck. Taking advantage of technological advances could play a role. As anyone with a smart phone knows, there have been amazing advances in communications technology in recent years. Major advances in mobile health and e-health are helping care providers reach vulnerable communities worldwide, many of whom speak indigenous languages. Automated translation and interpretation services could help reduce the costs of language services and improve their accessibility. However, it will be important to test automated translations of medical information for accuracy and comprehension before widespread use to avoid medical errors and misunderstanding.

The nation has a mixed record and remains divided regarding the extent to which certain groups of immigrants and their children should have access to health insurance and health care.

VI. Issues for Future Consideration

Overall, the nation has a mixed record and remains divided regarding the extent to which certain groups of immigrants and their children should have access to health insurance and health care. Regardless of medical needs or poverty, our laws and policies separate care by immigration status.

As the data show, noncitizen immigrants are far less likely to be insured than citizens, because of disparities in access to both private job-based coverage and public coverage. Low-income children who are citizens, but whose parents are not, are slightly more likely to be uninsured than children in citizen families; children who are themselves noncitizens, meanwhile, are far more likely to be uninsured. Immigrant children and adults are also less likely to use regular office-based medical care or emergency-room care than the low-income native-born.

Nonetheless, the United States has made limited progress in some areas, including the enactment of the ICHIA option in 2009 and the implementation of standards for language access. Beginning in 2014, the ACA will permit further expansions of health insurance coverage, both through health insurance exchanges and federal tax credits — which will be implemented in all states — and Medicaid expansion,



which will be implemented in many, but not all, states. The net effect is that there will be a major expansion of LPRs' eligibility for insurance, although it appears likely that unauthorized immigrants and those who are in provisional status will remain uncovered by Medicaid or the health insurance exchanges. In sum, policies that bar coverage because of legal immigration status persist. Unauthorized immigrants may be unable to purchase private health insurance through the new health insurance exchanges, even if they are willing to pay the full cost of coverage. And some LPRs who have been residents for fewer than five years will continue to be ineligible for Medicaid and, although they may be eligible for the exchanges and tax subsidies, may still find insurance unaffordable.

The prospect of a new federal immigration reform law offers the possibility of further changes and improvements for both current and future immigrants to the United States and their families. But, as mentioned before, it is too early to know the final outcome of what is likely to be a contentious struggle in Congress. In the meantime, there are other, less contentious steps that could be taken to improve access to health insurance and health care and to reduce language barriers for immigrants and their children at federal and state levels.

For more on MPI's National Center on Immigrant Integration Policy, visit:
www.migrationpolicy.org/integration



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About the Authors



Leighton Ku, Ph.D., M.P.H., is a Professor and Director of the Center for Health Policy Research in the Department of Health Policy in the School of Public Health and Health Services at the George Washington University.

For more than 20 years, he has conducted research and analysis regarding health care for disadvantaged populations, including studies of health care reform at national and state levels, Medicaid, safety-net health care, and immigrants. Prior to coming to George Washington, Dr. Ku was a Senior Fellow at the Center on Budget and Policy

Priorities and a principal researcher at the Urban Institute.

He has a Ph.D. in health policy from Boston University and an M.P.H. from the University of California, Berkeley.



Mariellen Malloy Jewers is a Senior Research Associate for the Aligning Forces for Quality program at the George Washington University. She is also a doctoral student at the Trachtenberg School of Public Policy and Public Administration, focusing on health policy. Previously, she was Associate for Social Policy at the Inter-American Dialogue and a social performance research fellow for FINCA International, where she conducted field research in Peru and El Salvador.

Ms. Jewers served as a Peace Corps volunteer in the Dominican Republic and an Americorps*VISTA volunteer in Massachusetts.

She received her BA in economics, Phi Beta Kappa, from the University of Massachusetts Amherst and holds an MA in international affairs from Columbia University's School for International and Public Affairs.



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www.migrationpolicy.org

1400 16th Street NW
Suite 300
Washington, DC 20036

Tel: 001 202-266-1940
Fax: 001 202-266-1900