This primer is designed to provide an introduction to some of the questions surrounding immigrants and health insurance coverage. A second primer will further explore how employment affects health insurance coverage of immigrants.

More in-depth materials on many of the topics raised in this primer are available at:

- Kaiser Commission on Medicaid and the Uninsured **www.kff.org/kcmu**
- National Council of la Raza **www.nclr.org**
- Center on Budget and Policy Priorities **www.cbpp.org**
- National Immigration Law Center **www.nilc.org**
- The Urban Institute **www.urban.org**

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IMMIGRANTS AND HEALTH COVERAGE: A PRIMER

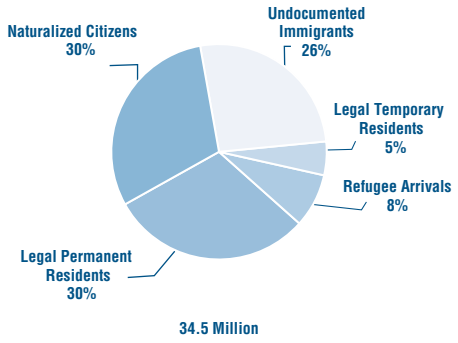
Immigrants are an integral part of the U.S., contributing both to the economy and diversity of the country. A major challenge facing many immigrants is lack of health insurance coverage, and, in recent years, the gap in overall health insurance coverage rates between low-income citizens and immigrants has widened. Health insurance helps assure that people receive preventive care and regular check-ups, are able to see a specialist or go to the hospital if needed, and are protected from high medical costs. It is important to address the lack of health coverage among immigrants, as lack of health insurance has been shown to have a significant negative impact on individuals' health and financial well-being.

HOW MANY IMMIGRANTS ARE THERE AND WHO ARE THEY?

Some 34.5 million immigrants were living in the U.S. in 2002, representing 12% of the population, and these numbers are expected to increase.[1] This represents all individuals living in the U.S. who were not citizens at birth, including recent arrivals and long-term residents. Most immigrants (74%) are here legally; undocumented immigrants account for 26% of immigrants (Figure 1).[2]

Figure 1

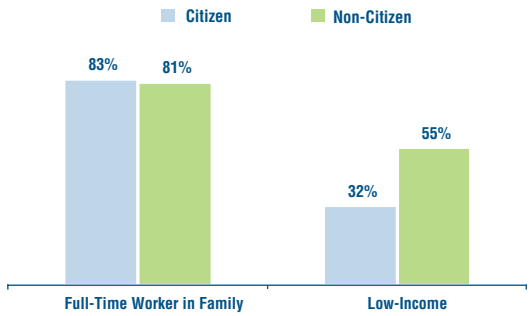
Legal Status of the Immigrant Population, 2002



Source: Urban Institute estimates based on March 2002 Current Population Survey.

Figure 2

Employment and Income by Citizenship Status, 2002



Note: Based on population. Low-income is less than 200% FPL or $31,340 for a family of three in 2004.

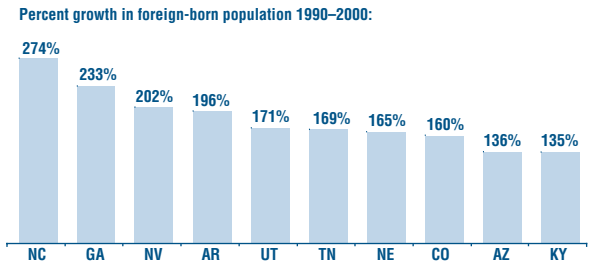
Source: Urban Institute and Kaiser Commission on Medicaid and the Uninsured analysis of March 2003 Current Population Survey.

The overwhelming majority of immigrant families have at least one full-time worker (Figure 2).[3] Even though non-citizen families are just as likely as citizen families to have a full-time worker in the family, they are much more likely to be low-income.[4]

Most immigrants are adults.[5] However, many children (both citizen and noncitizen) live in a family with at least one immigrant parent.[6] Just over half of the immigrant population was born in Latin America, one quarter came from Asia, and the remainder came from Europe and other regions of the world.[7] The share of immigrants who were born in Latin America has increased sharply—from 31% in 1980 to over half today.[7] However, the composition of the growing Latino population is changing—second generation U.S.-born children are outpacing immigrants as the major source of Latino growth.[9]

Figure 3

States with the Highest Growth in Immigrant Population in the 1990's



Source: "The Dispersal of Immigrants in the 1990's", November 2002, The Urban Institute.

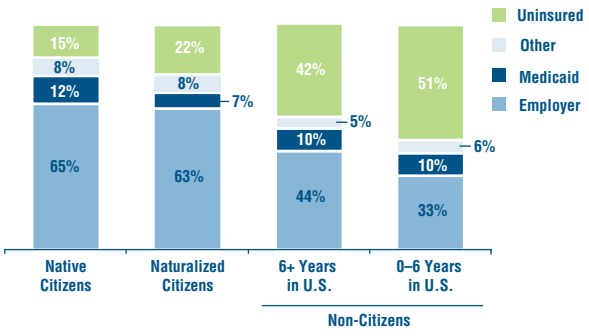
Immigrants are concentrated in certain areas of the country, but the destinations that immigrants choose are changing and diversifying. Over two-thirds of immigrants live in six states: California (28%), New York (12%), Texas (9%), Florida (9%), New Jersey (5%) and Illinois (5%).[10] However, the states with the fastest growing immigrant populations look very different—most are in the Southeast and Mountain regions of the country (Figure 3). North Carolina, Georgia and Nevada top the list—all with growth rates above 200% over the last decade.

DO IMMIGRANTS HAVE HEALTH COVERAGE?

While the overwhelming majority of immigrants are in working families, many work in jobs that do not offer health insurance. Medicaid and SCHIP play an important role in covering some low-income immigrants, but federal legislation restricts many immigrants, particularly recent immigrants, from qualifying for or enrolling in this coverage. As a result of low-paying jobs without health insurance and restrictions on public coverage, immigrants are significantly more likely to be uninsured than citizens. Between 42% and 51% of non-citizens lack health coverage, compared to 15% of native citizens (Figure 4).[11] Despite these high uninsured rates, research findings indicate that new immigrants are not primarily responsible for the growth in the overall uninsured population, mainly because their numbers are still small compared to the U.S. population as a whole.[12]

Figure 4

Health Insurance Coverage by Citizenship Status, 2002



Note: Based on nonelderly population. Other includes private non-group, Medicare, and CHAMPUS.

Source: Urban Institute estimates based on March 2002 Current Population Survey.

WHY DO IMMIGRANTS HAVE LOW RATES OF EMPLOYER-SPONSORED COVERAGE?

The majority of U.S. citizens get their coverage through the workplace. While the vast majority of immigrants (81%) have a full-time worker in the family,[13] many of their jobs do not offer health coverage. A disproportionate number of immigrants work in low-wage jobs, in small firms, and in labor, service, or trade occupations, which are less likely to offer health benefits.[14] Thus, while two-thirds of native citizens get their health insurance through their employer, between 33% and 44% of non-citizens have employer-based coverage.[15]

WHAT ROLE DO MEDICAID AND SCHIP PLAY IN COVERING IMMIGRANTS?

Medicaid and SCHIP, the nation's major health coverage programs for low-income people, play an important role in filling the gap in employer-sponsored coverage for some low-income immigrants. However, immigrants' eligibility for Medicaid and SCHIP is restricted. In 1996, Congress passed the Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA), which imposed a five-year ban on receipt of health and other public benefits on most newly arrived legal immigrants.[16] After this five-year bar expires, an immigrant family may still be ineligible for public coverage as a result of "sponsor deeming" rules, which attribute the income of an immigrant's sponsor to the immigrant, thus, potentially rendering many families ineligible.[17] Undocumented immigrants are ineligible for Medicaid, with the exception of emergency medical services covered by Medicaid.

Medicaid and SCHIP remain important sources of coverage available to immigrants who have been legally residing in the U.S. for at least five years and to citizen children of immigrant parents—most children living in low-income immigrant families are citizens. States also have the option to use SCHIP funds to provide prenatal care to women regardless of their immigration status—eight states were utilizing this option as of May 2004.[18]

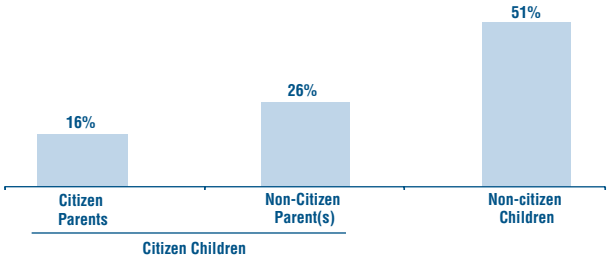
Additionally, as of May 2004, 21 states had stepped in to provide fully state-funded "replacement" programs for some or all legal immigrants who are not eligible for Medicaid or SCHIP due to the five-year bar.[19] In some cases, this coverage is only available to certain legal immigrants, such as pregnant women or children, and some state-funded programs provide significantly limited coverage. A few states have cut or are considering cutting back on state-funded coverage as part of their efforts to close state budget shortfalls. For example, Connecticut and Massachusetts eliminated coverage for some groups and Washington moved immigrants from Medicaid look-alike coverage to a program with limited benefits and premium and cost sharing requirements.[20] Connecticut and Massachusetts later restored their state-funded programs;[21] the changes in Washington have led to significant coverage losses among immigrants.[22]

While some believe that immigrants rely heavily on Medicaid and SCHIP, the reverse is actually true. Immigrants who may qualify for coverage themselves or who have citizen children who qualify often are confused or scared about enrolling. Fear of being labeled a "public charge," which leads to ineligibility for citizenship and possible deportation, has caused a decline in immigrant families' enrollment in public programs. In 1999, federal guidance clarified that receipt of Medicaid or SCHIP is not grounds for being declared a public charge; however, there is still a substantial amount of fear and confusion around enrolling in Medicaid or SCHIP among the immigrant community.[23]

Due to the eligibility restrictions and confusion and concern around enrolling, low-income immigrants are much less likely to have public coverage than low-income native citizens. In 2002, among low-income people, nearly a third of native citizens had Medicaid or SCHIP coverage, compared to 14 percent of immigrants residing in the U.S. for less than 6 years and 16 percent of immigrants residing in the U.S. for 6 or more years.[24] These issues also impact the large number of low-income immigrant children and citizen children of immigrant parents. One out of every four low-income children is living in a family with at least one foreign-born parent, and many of these children are eligible for Medicaid or SCHIP.[25] However, low-income immigrant children and citizen children living with an immigrant parent are much more likely to be uninsured than citizen children with citizen parents (Figure 5).[26]

Figure 5

Uninsured Rates of Low-Income Children, by Citizenship Status, 2001



Note: Low-income means family income was under 200% of the poverty level, which was $30,520 for a family of three in 2003.

Source: Ku L, Waidmann T. "How Race/Ethnicity, Immigration Status and Language Affect Health Insurance Coverage, Access to Care and Quality of Care Among the Low-Income Population." Kaiser Commission on Medicaid and the Uninsured, August 2003.

CONCLUSION

The immigrant population plays an important role in the U.S, with the overwhelming majority here legally and employed. Lack of health insurance coverage is a major issue facing immigrants, and increasing their coverage rates is critical to assuring their well-being. Health insurance makes a difference in whether and when people get necessary medical care, where they get their care, and, ultimately, how healthy people are. The uninsured are up to three times more likely than those with insurance to report problems getting needed medical care and are less likely to receive preventive care.[27] Further, the uninsured often face significant burdens paying medical bills.[28] Immigrants without health insurance have less access to health care and are less likely to obtain needed care than immigrants with insurance.[29] These problems are compounded for immigrant families who do not speak English (especially Latinos), who are more likely to be uninsured and to experience problems accessing care.[30]

Even though most immigrants are in working families, they often work in jobs that do not offer health coverage. Medicaid and SCHIP play a critically important role in filling this coverage gap for low-income immigrants, but public coverage for immigrants is limited by eligibility restrictions imposed by the federal government. A number of states have stepped in to provide coverage for some or all immigrants who are subject to these federal restrictions, but availability of this coverage varies across states, and, in some cases, this coverage is limited. Many immigrants who are eligible for Medicaid or SCHIP are concerned or confused about enrolling in these programs, so efforts to help eligible immigrants overcome these enrollment barriers are essential. In addition, developing further policy options to extend health insurance coverage to immigrants is an important policy priority.

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17 It is unclear what policies states will adopt on sponsor deeming as of this writing. For a detailed explanation of these complex eligibility rules, see *A Guide to Immigrant Eligibility for Federal Programs* from the National Immigration Law Center.
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The Kaiser Commission on Medicaid and the Uninsured provides information and analysis on health care coverage and access for the low-income population, with a special focus on Medicaid's role and coverage of the uninsured. Begun in 1991 and based in the Kaiser Family Foundation's Washington, DC office, the Commission is the largest operating program of the Foundation. The Commission's work is conducted by Foundation staff under the guidance of a bipartisan group of national leaders and experts in health care and public policy. Additional copies of this publication (#7088) are available on the Kaiser Family Foundation's website at www.kff.org.