Gaps in Coverage for Children in Immigrant Families

Gabrielle Lessard and Leighton Ku

One in every five American children is a member of an immigrant family. Despite their substantial numbers, these children are much less likely to have health insurance and ready access to health care than children in native-born citizen families. Family immigration status is, in fact, one of the most important risk factors for the lack of health care coverage among children in the United States. About one-third of the nation’s low-income, uninsured children live in immigrant families (see Figure 1). Almost all of these children meet the income requirements for eligibility for Medicaid or the State Children’s Health Insurance Program (SCHIP), but for various reasons they are not enrolled. For example, some of these children are ineligible for Medicaid and SCHIP because of immigrant eligibility restrictions. Many others are eligible but not enrolled because their families encounter language barriers to enrollment, are confused about program rules and eligibility status, or are worried about repercussions if they use public benefits. Not only are children of immigrants more likely to be uninsured and less likely to gain access to health care services than children in native families, but communication barriers can also result in immigrant children receiving lower-quality services.

The linguistic, cultural, legal, and socioeconomic circumstances of immigrants pose special challenges and opportunities for policy officials and health care practitioners seeking to provide health care and health insurance coverage to children in immigrant families. And because children in immigrant families constitute such a large share of the nation’s uninsured, successfully reducing the total number of uninsured children depends in large measure on how well the needs of immigrant families are addressed. Furthermore, immigrants are increasingly a concern for every state. Although immigrants traditionally have been concentrated in a handful of states—California, Florida, New Jersey, New York, and Texas—an increasing number are relocating throughout the country in pursuit of employment. Seventy percent of immigrants still reside in California, Florida, New Jersey, New York, and Texas, but the immigration growth rate during the 1990s was highest in southern and central states such as Iowa, Nevada, North Carolina, and Virginia. Health care and social service providers across the country are learning how to adjust their services to accommodate the needs of immigrant families.

Federal, state, and local policies and practices can either promote or undermine insurance coverage and access to care for this large but underserved population. This article discusses the barriers immigrant children face in securing health coverage and quality care and describes

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strategies that have been adopted to overcome these barriers. The article concludes with policy recommendations and suggestions for future steps to improve public health insurance programs for immigrant children.

**Children in Immigrant Families—A Diverse Population with Shared Concerns**

Speaking of “children in immigrant families” as a homogeneous group is misleading because these children are extremely diverse. Immigrant families come from every country in the world, speak a multitude of languages, and bring a host of cultural traditions to their new homeland. Most children in immigrant families are U.S.-born and therefore are native citizens whose parents are immigrants, but many other children are foreign-born noncitizens. Despite this diversity, immigrant families have shared challenges and concerns. This section details some of the most common barriers that impede immigrant families’ access to health coverage, including federal eligibility rules and fear of jeopardizing immigration status. The section also describes communication barriers that can influence the quality and cost of health care that immigrant families receive, as well as their use of health services and satisfaction levels with their health care.

**Barriers to Securing Health Insurance Coverage**

Regardless of immigration status, children from low-income families often lack adequate health insurance. But immigrant children are uninsured in even greater numbers than their low-income peers in citizen families, a disparity that has increased over time. For example, in 2000, about one-half of low-income noncitizen children and more than one-quarter of low-income citizen children with noncitizen parents were uninsured.
(see Figure 2). In comparison, one-sixth of low-income children from citizen families lacked coverage.\(^5\) Moreover, the share of low-income noncitizen children who were uninsured increased by seven percentage points from 1995 to 2000, while the share of low-income citizen children who were uninsured fell by 2\% during the same period (see Figure 3).

One key factor that affects these children’s health coverage is the economic and employment status of their immigrant parents. A disproportionate share of immigrant parents hold low-wage, poor-quality jobs that do not offer employer-sponsored insurance coverage, so their families lack access to private insurance coverage.\(^6\) Other factors, discussed below, also contribute to their weak insurance coverage, including federal eligibility rules, fears of jeopardizing immigration status, and language and cultural barriers.

**Figure 2**

**Insurance Status of Children in Families with Incomes Below 200\% of the Federal Poverty Level, by Citizenship Status, 2000**

![Graph showing insurance status of children](image)

**KEY:**
- **Job-Based Insurance**
- **Medicaid or SCHIP**
- **Other Insurance\(^a\)**
- **Uninsured**

\(^a\)Includes other private and public insurance such as private nongroup insurance or Medicare.


**Federal Eligibility Rules**

Medicaid and SCHIP are not available to many immigrant children because of eligibility restrictions imposed by the 1996 welfare reform law. Immigrant families have varied immigration statuses that confer different legal rights and affect the extent to which these families are eligible for public programs such as SCHIP and Medicaid (see Table 1). Moreover, the immigration status of children in the same family may differ. As a result, a foreign-born child may be ineligible for insurance coverage, while his or her younger, U.S.-born sibling is eligible as a native citizen.

As Figure 3 shows, the share of noncitizen children covered by Medicaid, and later SCHIP, dropped by nearly eight percentage points from 1995 to 2000. Other studies have found that citizen children in immigrant families also lost Medicaid coverage after the
1996 welfare law was passed.7–9 The decline in approved applications for immigrant families is primarily attributable to a decline in application submissions. Considering the substantial changes in welfare regulations and requirements, immigrant families may not have applied because they were unclear about their eligibility status or were fearful that they would be reported to the Immigration and Naturalization Service (INS).10

Table 1

<table>
<thead>
<tr>
<th>Immigration Status</th>
<th>Definition</th>
<th>Program Eligibility Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>Native citizen</td>
<td>Born in the United States</td>
<td>Eligible</td>
</tr>
<tr>
<td>Naturalized citizen</td>
<td>Foreign-born, but became a U.S. citizen through naturalization</td>
<td>Eligible</td>
</tr>
<tr>
<td>Lawful permanent resident</td>
<td>Noncitizen with permission to live and work permanently in the United States; has a “green card”</td>
<td>Under 1996 welfare law, those admitted after August 22, 1996, are ineligible during their first five years in the United States, but may receive emergency medical treatment during this period. Other immigrant-specific eligibility rules may pertain even after the five-year period expires.</td>
</tr>
<tr>
<td>Refugee/asylee</td>
<td>Admitted to the United States because of fear of persecution in the home country</td>
<td>Eligible for at least first seven years in the United States, under 1996 welfare law</td>
</tr>
<tr>
<td>Undocumented alien</td>
<td>Either entered the United States without permission or violated the terms of his or her visa</td>
<td>Not eligible, but may receive emergency medical care</td>
</tr>
<tr>
<td>Other lawfully present</td>
<td>Includes foreign-born people with temporary visas (for example, students, work visas, tourists), persons granted temporary protected status, applicants for asylum, and others with pending immigration status</td>
<td>Not eligible, but some may receive emergency medical care</td>
</tr>
</tbody>
</table>


Although qualified immigrants become eligible to receive federal benefits after five years of U.S. residency, other rules interfere with their access to benefits, including health insurance. For example, people who immigrated through family “sponsors”11 may have their sponsors’ income counted in determining eligibility. This “sponsor deeming” rule applies even if the sponsor lives in a separate household and does not actually contribute to the immigrant’s financial support. Sponsor deeming will likely make a majority of low-income immigrants ineligible for benefits, even after five years have passed.12 Moreover, if an immigrant uses certain benefits, including Medicaid and SCHIP, his or her sponsor can be required to repay the government for the value of the benefits used until the immigrant becomes a citizen or has had approximately 10 years employment in the United States. Together, these requirements impose tough barriers to securing health coverage, even when immigrant children are eligible.
In 1998, as states began to implement SCHIP, they began efforts to identify and enroll low-income, uninsured children. At the same time, this effort brought to light the paradoxes regarding the insurance coverage of immigrant children. While the 1996 welfare law made recent immigrant children ineligible, data about insurance coverage of children showed that a large share of uninsured children—about one-third—lived in immigrant families. To reach citizen children in immigrant families, state and local organizations developed initiatives to reach immigrant families, such as conducting outreach in multiple languages and engaging trusted community organizations to help identify and enroll these children. As seen in Figure 3, Medicaid or SCHIP participation of citizen children in noncitizen families recovered somewhat by 2000, suggesting at least partial success of ethnically oriented outreach efforts.

Despite these efforts, citizen children in immigrant families remain much more likely to be uninsured than children in native-born families. Children with one or more undocumented family members appear to have the highest levels of poverty and uninsurance.\textsuperscript{13,14} Undocumented persons are ineligible for Medicaid and SCHIP, except for emergency Medicaid services. Because undocumented persons cannot work legally,
Given the cultural and linguistic diversity of immigrant families, many encounter problems securing health coverage because of language barriers.

they are subject to exploitation in the labor market and encounter special difficulties securing private health insurance for their families.15

Fear of Jeopardizing Immigration Status
Even when eligible for public health insurance coverage, immigrant families often do not enroll, because they fear that receiving benefits might jeopardize family members' immigration status. For example, U.S.-born children of undocumented immigrants are qualified to receive Medicaid or SCHIP, but their parents may be reluctant to enroll them because of fear of exposing their own status. Moreover, in the mid-1990s, immigration and consular officials began to scrutinize immigrants' use of health care benefits. Immigrants learned that their use of health benefits categorized them as “public charges” (an immigration term for people who depend on public aid), jeopardizing their residency. People deemed public charges can be denied entry to the United States, denied reentry after travel abroad, or refused lawful permanent residency. Some officials told immigrants that to remain in or reenter the United States, they would have to repay Medicaid benefits that they or their children had legitimately received.16

In light of public health concerns raised by health care providers, state and county governments, advocates, and the immigrant community, the INS clarified that the use of health care programs such as Medicaid and SCHIP (other than long-term care) should not be considered in public charge determinations.17 Yet a survey conducted in 2000 found that about three-quarters of low-income immigrants continue to believe that there may be some negative repercussions—for example, inability to get a green card or become a citizen—if they or their children receive public benefits such as Medicaid or food stamps.18

Language and Cultural Barriers
Given the cultural and linguistic diversity of immigrant families, many encounter problems securing health coverage because of language barriers.19 A recent study of low-income Latino immigrants and their children suggests that a lack of English proficiency is an important risk factor for being uninsured.20 The study found that low-income noncitizen immigrants who primarily spoke Spanish were less likely to have insurance coverage for their children or themselves than similar noncitizen immigrants who spoke English. An immigrant with limited English proficiency may have poorer access to insurance for diverse reasons: He or she might not understand outreach messages, be aware of public insurance programs, or be able to complete an application for Medicaid or SCHIP, and might have difficulty getting a high-quality job that offers health benefits. In addition, those with limited English have often been in the United States for a shorter time, are less acculturated, and have poorer educational backgrounds than those with stronger English skills.

Finally, the need to secure insurance to help defray the high costs of medical care may simply be an unfamiliar concept to some immigrants, especially those from countries with universal health care and state-run health care systems. Nonetheless, cultural preferences for health insurance probably do not differ greatly. For example, when employers offer insurance to noncitizen Latino workers, about 80% accept the insurance, a rate similar to that of white and Latino citizen workers.21 The study suggests that immigrants, like citizens, want health insurance; they simply face more barriers to obtaining coverage.

Barriers to Accessing Quality Health Care
The challenge of improving health outcomes for children in immigrant families is affected not only by difficulties in securing health insurance coverage, but also by the limited access these children have to quality health care. Children in immigrant families have less access to health care than similar children in citizen families, and they may receive less-satisfactory health care services.22–24 More than one-eighth of low-income, U.S.-born children with noncitizen parents and more than one-quarter of low-income noncitizen children do not have a “medical home”—that is, a...
usual place to get health care. As shown in Figure 4, these rates are two to four times higher than those for children of citizens with similar income levels.\textsuperscript{25} For about one-half of the children of immigrants, a clinic or hospital outpatient department is their usual source of care. Many of these safety net providers are strained by resource limits or are able to offer only limited services.\textsuperscript{26} In addition, case studies in high-immigration cities indicate that immigrants often use low-cost or unregulated forms of health care, such as informal or unlicensed health care providers, self-diagnosis, or medications purchased in questionable settings.\textsuperscript{27}

Even after adjusting for race, income, education, health status, and similar factors, children in immigrant families—including both foreign- and U.S.-born children—have significantly less access to primary medical or dental care than children in native-born citizen families.\textsuperscript{28} Children in immigrant families also use emergency room services less than those in citizen families, contrary to the notion that those with poor access to primary care overuse the emergency room.\textsuperscript{29}

The lack of medical homes for children in immigrant families is not surprising given their problems securing insurance coverage. Like most people, children of immigrants have substantially better access to health care services when they have insurance. Nonetheless, data show that even insured children of immigrants have poorer access to health care services than insured children in native citizen families. These data suggest that children of immigrants face other, nonfinancial, barriers to health care.\textsuperscript{30}

The most significant nonfinancial barrier appears to be the communication problems that occur when physicians, nurses, receptionists, and other health care staff fail to provide interpreters or other language assistance for patients with limited proficiency in English. As the next section details, language barriers can impede immigrants’ access to and use of health care, as well as

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**Figure 4**

**Usual Source of Medical Care for Low-Income Children, by Citizenship Status, 1997**

<table>
<thead>
<tr>
<th>Source of Care</th>
<th>Noncitizen Children</th>
<th>Citizen Children with Noncitizen Parents</th>
<th>Citizen Children with Citizen Parents</th>
</tr>
</thead>
<tbody>
<tr>
<td>Doctor's Office</td>
<td>25.1</td>
<td>32.3</td>
<td>57.8</td>
</tr>
<tr>
<td>Clinic or OPD\textsuperscript{a}</td>
<td>47.1</td>
<td>53.4</td>
<td>33.3</td>
</tr>
<tr>
<td>Emergency Room</td>
<td>1.9</td>
<td>1.1</td>
<td>2.7</td>
</tr>
<tr>
<td>No Usual Source</td>
<td>25.7</td>
<td>13.0</td>
<td>6.0</td>
</tr>
</tbody>
</table>

\textsuperscript{a}Outpatient department.

the quality of care they receive and their satisfaction with that care. Language barriers may also lead to increased costs.

**Language Affects Access and Use**

Language barriers can prevent eligible immigrants from applying for programs and visiting health care providers. For example, Latino parents have reported that language barriers are the leading problem they face in obtaining care for their children. In one study, one-half of Spanish-speaking Latino parents could not complete Medicaid applications for their children because the forms were not translated, and interpreter assistance was not available. Chinese, Korean, and Vietnamese parents have reported similar problems.

In another study, nearly one-fifth of Spanish-speaking Latinos said they did not seek needed care either because the doctor did not speak Spanish or there was no language interpreter available. One recent analysis found that the probability of having seen a physician during the prior year was substantially higher for low-income children of immigrants who spoke English than for children whose immigrant parents primarily spoke Spanish.

Problems may be even more severe for immigrants who speak less common languages, such as Vietnamese, Chinese, Korean, Haitian Creole, or Russian, for which bilingual health staff or interpreters are harder to find. Similarly, problems may arise when health care providers do not understand their patients' cultures or health beliefs.

**Language Affects Quality and Patient Satisfaction**

Language barriers also affect the quality of care that immigrants receive and their satisfaction with that care. Spanish-speaking parents have reported that their children have received misdiagnoses, poor medical care, and inappropriate medications because of language problems. In a recent survey, more than one-quarter of patients who needed—but did not get—an interpreter reported that they did not understand instructions about how to take their medications. The same study indicated that these patients were also less likely than those who had interpreters to have been told about financial assistance available for medical bills.

Noncitizen parents who speak Spanish are much less likely than English-speaking immigrant parents to report that their child’s physician listened to them and explained things clearly. Not surprisingly, research shows that Spanish-speaking Latinos were much less satisfied with medical care than English-speaking Latinos or English-speaking non-Latinos.

**Language May Increase Costs**

Communication problems may also increase the cost of care. A study of pediatric emergency room patients found that the average charges for medical tests were significantly higher, and that emergency room stays were longer, when language barriers existed between physicians and patients' families.

In summary, children in immigrant families face major obstacles to securing health coverage and, once they have access, to receiving quality health care. Barriers to access include federal rules that restrict eligibility for public programs, and fears about jeopardizing immigration status by participating in public programs. Once families have access, communication barriers can negatively affect the quality and cost of care that they receive, as well as the frequency with which they use health services for their children.

**Strategies for Expanding Access**

Recognizing that eliminating barriers to insurance and health care access will improve public health, many states and local communities have developed strategies for covering immigrant children within the boundaries of federal immigrant eligibility restrictions. This section highlights some of the strategies that states, communities, and nonprofit organizations have developed to strengthen insurance coverage and access to care for children in immigrant families.

**State-Funded Replacement Programs**

States can use their own funds to provide health coverage to children whose immigration status makes them ineligible for federally funded services. As of September 2002, 23 states (including the District of Columbia) provided some form of state-funded, nonemergency health coverage for immigrant children who were not eligible for Medicaid or SCHIP (see Figure 5). These state efforts are generally referred to as “state
replacement programs” because they replace some of the benefits the federal government provided to immigrants before the 1996 welfare law. Eligibility rules and benefit packages vary among states. A few states extend coverage to groups ineligible under the pre-1996 rules. For example, the District of Columbia, Massachusetts, New York, and Rhode Island provide at least some coverage for undocumented children.45

State Medicaid or SCHIP agencies typically administer state replacement programs. Such centralization provides an opportunity for an agency to use simple, inclusive outreach messages and a coordinated application process to facilitate program enrollment. This approach is particularly helpful for families with children of varying immigration status and program eligibility status.

State replacement programs provide essential medical services to immigrant children barred from Medicaid and SCHIP by federal rules, but the programs are vulnerable to budget cuts in periods of fiscal pressure. During slow economic periods, states’ Medicaid expenditures tend to surge while revenues fall, causing many states to contemplate cutbacks in Medicaid programs.46 Further, unlike regular components of Medic-
aid, replacement programs draw no federal matching funds, making them more susceptible to budget reductions. Yet, money spent on replacement programs may help states avoid a large portion of the expenses they would otherwise incur in providing emergency Medicaid care to immigrants.47

About one-half of the states do not provide replacement programs for immigrant children. In these states, recently immigrated children have access to emergency Medicaid only. Both states and the federal government are required to cover eligible immigrants’ emergency medical care under Medicaid. Clinics and charity care provide additional resources in some communities, but these safety net providers are heavily burdened, and many communities lack free or low-cost safety net providers.48 For example, in California, which has almost 30% of the nation’s immigrant population, six counties have no community clinics.

When immigrant families lack full coverage, they may defer care for their children until preventable or easy-to-treat conditions progress, requiring more intensive and costly interventions.49 This practice may lead to worse outcomes for a child and strain an already burdened emergency services network.50

**Local Coverage Initiatives**

Some communities have developed their own local initiatives to provide health coverage to uninsured immigrant children. The Children’s Health Initiative (CHI) in Santa Clara County, California, was one of the earliest local initiatives. CHI provides universal health coverage for all children ineligible for Medicaid and SCHIP, up to 300% of the FPL, regardless of immigration status. Outreach and enrollment for CHI are combined with outreach and enrollment for Medicaid and SCHIP, and the program uses the SCHIP provider network. The program is supported by an innovative combination of public and philanthropic funds. (See the article by Wong in this journal issue for further discussion of the Santa Clara initiative.)51

**Culturally Competent Outreach and Enrollment**

As discussed previously, eligibility for health coverage does not always lead to the enrollment of immigrant children in available programs. Culturally appropriate, community-based outreach is essential to ensuring immigrant children’s participation in health insurance programs.

The complexity of immigration eligibility rules invites misinterpretation. Outreach in immigrant communities often involves addressing concerns or correcting misinformation that may have come from trusted sources like relatives or perceived experts. Many immigrant communities are besieged by unlicensed purveyors of immigration assistance, whose understanding of the law can be out of date or simply wrong.52 Outreach workers in immigrant communities need training to understand families’ concerns, time to develop relationships of trust, and technical support from immigrant rights and legal services organizations to accurately interpret eligibility rules.

Working with trusted community-based organizations (CBOs) is an effective way to identify and enroll uninsured immigrant children. Many CBOs concentrate on issues other than health care access, however, and most must stretch scarce resources across a range of community needs. Partnerships that bring together the resources of health groups and the expertise of culturally competent CBOs can further immigrant children’s enrollment. One example of such a partnership is the collaboration between the Illinois Coalition for Immigrant and Refugee Rights and the state’s Department
of Human Services. The two organizations work together to improve CBOs’ capacity to promote immigrant access to public health coverage and other services. The coalition receives funds from the state to provide technical assistance to CBOs and to train CBOs on outreach strategies, case counseling, and language assistance. This partnership has resulted in more uninsured immigrant families applying for and using health services for which they are eligible.

Some communities have a tradition of health-related outreach that naturally supports health coverage enrollment efforts. For example, many Latino communities are served by community health outreach workers called promotoras. Promotoras are typically immigrant community volunteers who provide health education and outreach in homes and at farm labor camps. Their roots in the community enhance their outreach efforts and enable them to promote retention in health coverage by helping enrolled families navigate the system.

**Addressing Language Barriers**

To improve immigrant children’s access to coverage and quality care, language barriers must be addressed. To deal with language barriers, outreach workers and organizations promoting access to health care can include education about the availability of language assistance as part of their efforts. Federal policy, under Title VI of the Civil Rights Act, requires providers who receive federal funds (including Medicaid and SCHIP funds) to ensure that people with limited English proficiency have meaningful access to services. Some state laws, regulations, and managed care contracts also require language assistance.

Unfortunately, these requirements are often not met. The cost of providing adequate interpretation services for clients who speak a multitude of languages may dissuade providers from offering such assistance. In some cases, providers may not even be aware of their obligations; or when providers are aware, immigrant families may not be. Agency enforcement efforts rely on complaints, and families with limited English proficiency may be unaware of their rights or afraid to assert them. More aggressive enforcement efforts by responsible agencies would increase the focus on the requirement to provide services. The federal Interagency Working Group on Limited English Proficiency has recently established a Web site that includes multi-language resources that community organizations can use to improve their language-assistance services.

One strategy for improving language services is to develop qualified bilingual staff. Some health care providers have formed pools of bilingual staff, who interpret as needed in addition to their regular duties. For example, Asian Health Services, a community-based clinic in Oakland, California, trains staff and bilingual community members in the skills necessary to become bilingual clinic service providers.

Another strategy is to engage professional interpreters, but they are often in short supply. Some CBOs have responded to this shortage by training community members to become qualified medical interpreters. For example, in Tennessee, Latino Memphis Conexcion collaborated with two county health departments and other CBOs to train Spanish-language interpreters and place them in health care settings throughout the city. Making interpreters available at the community level can help provide services in more languages and at a lower cost than can placing interpreters with individual providers. Such efforts also create employment and professional development opportunities for community members.

**Extending Access to Undocumented Children**

Even if Medicaid and SCHIP coverage were extended to immigrants who were eligible for public benefits before welfare reform, access to health care would improve only for lawfully present immigrant children. Children who are undocumented would not be helped. Streamlining enrollment for emergency Medicaid coverage is one option already permitted under federal law for covering undocumented children. When children’s immigration status makes them ineligible for “full scope” Medicaid, states typically enroll them into emergency Medicaid on an ad hoc basis after an emergency occurs. States are also permitted to enroll undocumented children in Medicaid in the same manner as other beneficiaries, but restrict their benefits to emergency services. One study found that California, which enrolls undocumented immigrants in advance, covers far more immigrants at a much lower per capita
cost than states enrolling immigrants after emergencies. While this approach would not provide access to the full range of preventive, primary, and rehabilitative services, it could nonetheless enhance access to emergency care and promote earlier and less costly interventions when emergencies arise.

Some communities have implemented local initiatives aimed at ensuring health coverage for all low-income children, including immigrants, and a few states have opted to use their own funds to insure children regardless of immigration status (see Figure 5). In addition to providing needed care and protecting the public health, these local initiatives have increased eligible children’s enrollment in Medicaid and SCHIP. The federal government could follow their example and extend full Medicaid and SCHIP coverage to income-eligible children, without regard to their immigration status. While such an extension of health insurance coverage presently seems politically unlikely, the country has recognized the benefits of providing a healthy start to all children in certain other programs. For example, undocumented children are currently eligible for nutrition programs such as school lunch and breakfast.

Another key strategy for helping undocumented children is to provide adequate financial support to safety net health care providers who offer free and subsidized care regardless of immigration status. These facilities provide a major share of care for low-income, uninsured immigrant families.

A final option, with wider implications, is to assist undocumented families in becoming legalized, either with legal assistance or through broader legislative efforts. At any given time, almost 20% of those counted as undocumented are either family members caught in INS backlogs or people applying for asylum. Others have characteristics that may make them eligible for an adjustment of their status, but they lack the legal advice needed to navigate the system and obtain the adjustment. In addition, Congress has considered proposals for legalizing certain groups of undocumented people, such as students. Even if persons legalized under such an effort were excluded from benefits like Medicaid or SCHIP, legalization could help families get better jobs and thereby improve their chances of securing private health insurance.

**Conclusion**

Children of immigrants represent a growing share of all American children, and their families are increasingly dispersed across the United States. Protecting and preserving the public health requires policymakers to confront the challenge of providing access to health care for these families.

Adequate health insurance coverage is a critical first step to accessible, quality health care; yet obtaining this coverage is far more burdensome for children in immigrant families than for their native-born peers. Immigrant families face difficulties in securing job-based insurance, and their eligibility for public health coverage is limited. Immigration concerns and language barriers inhibit enrollment in programs for which families are eligible, and a lack of culturally and linguistically appropriate services further limits access to quality care. Major efforts are needed to increase the number of immigrant children with access to quality health care. Three elements are key: restoring and expanding federal eligibility rules for Medicaid and SCHIP; working with trusted community groups; and improving linguistic and cultural competence.

**Restoring Eligibility**

A primary focus must be restoring the federal eligibility for public health coverage for lawfully present immigrants that was curtailed by the 1996 federal welfare law. In addition to aiding the large number of low-income immigrant children who are now barred, restoring immigrant eligibility could help states simplify their application processes for all children. Currently, families must be told that some lawfully present children are eligible, while others are not. Establishing equitable eligibility rules for immigrant and citizen children would improve and simplify outreach efforts by sending a clearer message to families.

Regardless of whether or not federal legislation is amended to restore immigrants’ eligibility for Medicaid and SCHIP, more states could take the initiative to fund state replacement programs to serve this needy population. The costs of providing preventive health care for children are modest and should be viewed as an incremental expense, since states already must cover emergency benefits for recent immigrant children.
Working with Community Groups
Restoring immigrants’ eligibility will not, by itself, guarantee enrollment or access to health care services. Recent experiences in SCHIP outreach and enrollment initiatives point to the importance of collaboration with trusted community groups who can explain the significance of health insurance coverage and help allay fears that getting medical assistance might endanger a family’s immigration status. Health care providers, state and local governments, and advocates have begun to document the existence and effects of barriers that limit access to health care, paving the way for helpful federal agency guidance and congressional restorations.

Improving Linguistic and Cultural Competence
Immigrant parents and their children need access to linguistically and culturally competent health care providers, as well as assistance in applying for health benefits and using the health care system. Although health care providers, managed care organizations, and insurers have begun to recognize that linguistic and cultural competence are integral to quality care, little is known about the most effective methods of ensuring meaningful access. In policy, practice, and research, more needs to be done to understand and reduce the disparities in access to quality health care services that affect the children of immigrants in the United States.

Government agencies, advocates, and community groups need to coordinate and collaborate in their efforts to craft policies that respond to the complexity of immigrant families’ needs and to eliminate the remaining barriers to providing adequate, accessible, and quality care for this significant proportion of children in the United States.

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ENDNOTES
2. Below 200% of the FPL.
4. Research shows that the problems of uninsurance for both foreign- and U.S.-born children of immigrants persist, even after statistically controlling for the effects of income, family composition, parental education and employment, race and ethnicity, health status, age, and gender. Ku, L., and Matani, S. Left out: Immigrants’ access to health care and insurance. Health Affairs (2001) 20(1):247–56. A noncitizen child is about 16 percentage points more likely to be uninsured than a similarly situated child of native citizen parents. A citizen child in a noncitizen family is about eight percentage points more likely to be uninsured.
5. These data are based on analyses of the March 2001 Current Population Survey (CPS), produced by the Center on Budget and Policy Priorities. Noncitizens include both legal and undocumented immigrants; the CPS does not differentiate these categories. Urban Institute analysts have imputed immigration status to the CPS data and estimate that more than one-half of the uninsured noncitizen children are undocumented (see the article by Holahan, Dubay, and Kenney in this journal issue). We note, however, that the imputation process is complex and impossible to verify; it may inadvertently introduce a substantial measure of imputation error. Analysts should be cautious about the interpretation of these data, with or without imputations.
6. One study found that noncitizen Latino workers were about half as likely as either Latino or white citizen workers to be offered job-based insurance coverage. Substantial disparities persisted, even when immigrants were compared with native workers who had similar wages, hours of employment, and occupations. Schur, C., and Feldman, J. Running in place: How job characteristics, immigrant status, and family structure keep Hispanics uninsured. New York: Commonwealth Fund, May 2001.
7. See note 4, Ku and Matani.
11. As a condition of family-related immigration—the most common form of legal immigration—an immigrant must be “sponsored” by a U.S. citizen or resident, typically a relative. Under 1996 laws, the responsibilities of sponsors were greatly increased, in order to reduce the number of immigrants who would be eligible for benefits such as Medicaid and SCHIP.

12. See note 4, Ku and Matani.


15. See note 4, Ku and Matani.


21. See note 6, Schur and Feldman.

22. See note 4, Ku and Matani.


25. See note 4, Ku and Matani.


28. See note 4, Ku and Matani.

29. See note 4, Ku and Matani.

30. See note 4, Ku and Matani.


32. For instance, a physician’s inability to understand the health problems being reported may lead to a misdiagnosis. The patient (or parent) might not understand the treatment options or regimen the physician describes, making informed decision making or compliance with medical orders impossible. Language barriers can also lead to more tests and longer emergency room stays, increasing care costs.


37. See note 20, Ku and Waidmann.

38. See note 33, Flores, et al.


40. See note 24, Granados, et al.


44. There is considerable variation among the state replacement programs shown on the chart. States shown as providing limited coverage do not extend health coverage to all categories of immigrants who lost eligibility under the 1996 welfare law. These include states, such as Florida, that cap enrollment for replacement programs, as well as states, such as New Mexico, Oklahoma, and Wyoming, that cover only a subset of immigrants who lost coverage, such as victims of domestic violence. Some states limit the services available through their replacement programs. Massachusetts, for example, provides only preventive and primary care to immigrants without qualified status. For more information on state replacement programs, see note 43, National Immigration Law Center. Additional information about state and local health programs is available in Zimmermann, W., and Tumlin, K. *Patchwork policies: State assistance for immigrants under welfare reform.* Washington, DC: Urban Institute, May 1999.

45. See note 43, National Immigration Law Center.


48. See note 26, Lewin and Altman.


56. For example, California’s Dymally-Alatorre Bilingual Services Act requires bilingual staffing and services at all state agencies where 5% or more customers speak a language other than English. The act notes that “the effective maintenance and development of a free and democratic society depends on the right and ability of its citizens to communicate with their government and the right and ability of the government to communicate with them.” California Government Code § 7291. San Francisco and Oakland, California, have enacted local ordinances that require key city departments to hire bilingual staff in public contact positions and to translate vital documents into the major languages spoken by residents with limited English proficiency. San Francisco Administrative Code, chapter 89; Oakland Municipal Code, chapter 2.30. See Perkins, J. Ensuring linguistic access in health care settings: Legal rights and responsibilities. Los Angeles, CA: National Health Law Program, January 1998.


61. See note 4, Ku and Matani.

62. See note 19, Feld and Power.

63. Lawfully present children who are ineligible for benefits include qualified immigrant children who arrived in the United States after August 22, 1996, and are subject to the five-year bar. See note 43, National Immigration Law Center.

64. Many members of Congress in both parties have expressed their recognition of this fact through their support for the Immigrant Children’s Health Improvement Act (ICHIA), which would restore Medicaid and SCHIP eligibility for lawfully present children and pregnant women, currently subject to a five-year ban on coverage. The provisions of this bill were included in the Senate Finance Committee’s version of the bill to reauthorize the Temporary Assistance to Needy Families (TANF) program in 2002. See National Immigration Law Center. Senate Finance Committee votes to include restoration of immigrant benefits in TANF bill. Immigrants Rights Update. July 15, 2002. Available at http://www.nilc.org/immspbs/TANF/TANF004.htm. When this article was revised in October 2002, it was not clear whether or not Congress would include the ICHIA provision in the 2002 version of a TANF reauthorization bill, or even if Congress would pass any reauthorization bill. As of February 2003, Congress has not approved ICHIA.