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# The Nexus between Immigrant Eligibility and Access: An Analysis of the Economic, Social, and Linguistic Barriers to Health Care

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*Introduction by Cory S. Bagby**

## I. INTRODUCTION

In a time of anti-immigrant rhetoric, complex eligibility rules, and difficult application and renewal processes in public health programs, immigrants face many barriers to accessing needed health services. At the First Annual Beazley Symposium on Access to Health Care at Loyola University Chicago School of Law, Sonal Ambegoaker, a health policy attorney at the National Immigration Law Center ("NILC"), spoke about the effect of these barriers, primarily within the context of public health insurance programs. In her role at the NILC, Ms. Ambegoakar analyzes and makes recommendations concerning federal, state, and local policies affecting low-income immigrants' access to affordable health care. Before joining NILC, Ms. Ambegoakar served as a supervising attorney at the Health Consumer Center of Los Angles, a project of Neighborhood Legal Services of Los Angeles County. In that position, she oversaw a multi-language consumer hotline that provides callers with assistance on a variety of access and health care issues. Ms. Ambegoakar earned her Juris Doctor degree from the University of California Davis School of Law.

In her presentation, Ms. Ambegoakar contended that hostility and discrimination based on a person's immigration status have manifested into restrictions on eligibility and complex enrollment and renewal requirements in public health insurance programs. These eligibility restrictions prevent many documented immigrants, who are otherwise eligible, from participating in Medicaid and the State Children's Health Insurance Program ("SCHIP")[1] for five years, even though they may be paying taxes

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1. SCHIP is a federally funded block grant program designed to increase the opportunity for states to provide health care benefits to low-income children who do not qualify for

to support such programs. Ms. Ambegoakar also pointed to the linguistics obstacles that prevent many eligible immigrants from program awareness and enrollment. Ms. Ambegoakar posits that shifting the debate to highlight immigrant contributions to society and educating the public on the societal benefits immigrants provide are among the potential methods to counteract anti-immigrant policies. The following introduction to Ms. Ambegoakar's presentation briefly summarizes immigrant eligibility to public health programs and the barriers immigrants face in accessing health care.

## II. THE AVAILABILITY OF HEALTH INSURANCE TO UNDOCUMENTED IMMIGRANTS

There are approximately thirty-one million non-elderly immigrants living within the United States.[2] Almost three-quarters of these immigrants are documented,[3] but for those immigrants who lack the appropriate documentation there is little access to health care services.

Due to the high cost of health care and the ability of physicians to deny services to those individuals who are unable to pay (except for emergency services), access to health services is often predicated on obtaining health insurance. Employer-based health insurance coverage is frequently unavailable to immigrants because they tend to work in low-wage jobs and in industries that do not traditionally offer health insurance to their employees.[4] In 2003, the median annual salary for a full-time, non-citizen employee was $23,140.[5] Nearly 40% of this group had incomes below $20,000 per year.[6] At the same time, private health insurance premiums have steadily increased.[7] Health care premiums in 2006 increased by an average of 7.7% and the average annual premium for a family of four exceeded $11,000.[8] Not surprisingly, employers who do offer private

Medicaid. Robert F. Rich, Cinthia L. Deye & Elizabeth Mazur, *The State Children's Health Insurance Program: An Administrative Experiment in Federalism*, 2004 U. ILL. L. REV. 107, 107 (2004).

2. JOAN C. ALKER & JENNIFER NG'ANDU, KAISER COMM'N ON MEDICAID & THE UNINSURED, THE ROLE OF EMPLOYER-SPONSORED HEALTH COVERAGE FOR IMMIGRANTS: A PRIMER 1 (2006), http://www.kff.org/uninsured/upload/7524.pdf.

3. JEFFREY S. PASSEL, RANDY CAPPS & MICHAEL FIX, URBAN INST. IMMIGRATION STUDIES PROGRAM, UNDOCUMENTED IMMIGRANTS: FACTS AND FIGURES 1 (2004), http://www.urban.org/UploadedPDF/1000587_undoc_immigrants_facts.pdf.

4. ALKER & NG'ANDU, *supra* note 2, at 2.

5. *Id.*

6. *Id.*

7. *See* NAT'L COAL. ON HEALTH CARE, FACTS ON HEALTH CARE COST 2 (2008), http://www.nchc.org/facts/2007%20updates/cost.pdf.

8. *Id.*

health insurance have increased employee contributions.[9] For immigrant families, particularly undocumented immigrant families, these costs can be an insurmountable financial burden.[10] As a result, many undocumented immigrants are either not offered employer based health insurance or simply cannot afford it.

Public health insurance programs are generally unavailable to undocumented immigrants. The Personal Responsibility and Work Opportunity Reconciliation Act of 1996 ("PRWORA")[11] made undocumented immigrants ineligible for most federal public benefit programs,[12] including Medicaid (except for emergency care), SCHIP, Temporary Assistance for Needy Families ("TANF")[13], Food Stamps, and Supplemental Security Income ("SSI").[14] In addition, PRWORA prohibits "qualified"[15] immigrants who entered the United States on or after August 22, 1996, from accessing these programs for five years.[16]

However, PRWORA does not prohibit states or localities from using their own funds to provide health insurance coverage to immigrants who are ineligible for federally funded health insurance programs.[17] Many states have used their own funds to provide coverage to low-income documented

9. ALKER & NG'ANDU, *supra* note 2, at 3.

10. *Id.*

11. Personal Responsibility and Work Opportunity Reconciliation Act of 1996, Pub. L. No. 104-193, 110 Stat. 2105 (1996) (codified as amended in scattered sections of 42 U.S.C.).

12. Neda Mahmoudzadeh, Comment, *Love Them, Love Them Not: The Reflection of Anti-Immigrant Attitudes in Undocumented Immigrant Health Care Law*, 9 SCHOLAR 465, 471 (2007).

13. TANF is a block grant implemented to give states greater flexibility in designing transitional assistance programs for low income families. States have used TANF funds to provide cash for basic needs, childcare, education, job training, and other forms of assistance designed to meet ongoing needs. Martha C. Nguyen, *Welfare Reauthorization: President Bush's Agenda*, 9 GEO. J. ON POVERTY L. & POL'Y 489, 489-90 (2002).

14. LEIGHTON KU, SHAWN FREMSTAD & MATTHEW BROADDUS, CTR. ON BUDGET & POLICY PRIORITIES, NONCITIZENS' USE OF PUBLIC BENEFITS HAS DECLINED SINCE 1996: RECENT REPORT PAINTS MISLEADING PICTURE OF IMPACT OF ELIGIBILITY RESTRICTIONS ON IMMIGRANT FAMILIES 1 (2003), http://www.cbpp.org/4-14-03wel.pdf.

15. Qualified immigrant categories include: lawful permanent residents or persons with greencards; refugees, persons granted asylum or withholding of deportation/removal, and conditional entrants; persons granted parole by the Department of Homeland Security for a period of at least one year; Cuban and Haitian entrants; and certain abused immigrants, their children and/or their parents. TANYA BRODER, NAT'L IMMIGRATION LAW CTR., OVERVIEW OF IMMIGRANT ELIGIBILITY FOR FEDERAL PROGRAMS 2 (2007), http://www.nilc.org/pubs/guideupdates/tbl1_ovrvw_fed_pgms_032505.pdf.

16. *Id.* at 4.

17. SHAWN FREMSTAD & LAURA COX, KAISER COMM'N ON MEDICAID & THE UNINSURED, COVERING NEW AMERICANS: A REVIEW OF FEDERAL AND STATE POLICIES RELATED TO IMMIGRANTS' ELIGIBILITY AND ACCESS TO PUBLICLY FUNDED HEALTH INSURANCE 10 (2004), http://www.kff.org/medicaid/upload/Covering-New-Americans-A-Review-of-Federal-and-State-Policies-Related-to-Immigrants-Eligibility-and-Access-to-Publicly-Funded-Health-Insurance-Report.pdf.

immigrants who are ineligible for Medicaid or SCHIP because of the five-year ban.[18] Although some of these states have extended these programs to undocumented immigrants who are otherwise ineligible for public benefit programs, the majority have not.[19]

In addition, documented and undocumented immigrants who meet the Medicaid eligibility requirements, except for eligibility restrictions based on immigration status, qualify for Emergency Medicaid in the case of a medical emergency.[20] Furthermore, the Emergency Medical Treatment and Active Labor Act ("EMTALA") requires hospitals to screen and stabilize all individuals, including immigrants, who seek emergent care.[21] While EMTALA mandates emergency care, it does not include funding to reimburse the cost of providing emergency treatment for the uninsured.[22] However, the Medicare prescription legislation enacted in 2003 includes a provision that provides $250 million dollars a year for fiscal years 2005 to 2008 to healthcare providers for costs related to providing uncompensated emergency treatment to undocumented immigrants.[23]

Documented and undocumented immigrants face many challenges in obtaining health insurance and accessing health care: employer-based health insurance is either unavailable or too costly, undocumented immigrants often do not qualify for federally funded public health insurance, and the majority of states do not provide health insurance benefits to low-income undocumented immigrants. With few options, undocumented immigrants will often forgo needed care and turn to emergency rooms only as a last resort.

## III. DOCUMENTED IMMIGRANTS AND THE FIVE-YEAR BAN

Unlike undocumented immigrants, naturalized citizens' access to health care is often comparable to that of natives.[24] However, documented immigrants that are not naturalized face many challenges to obtaining health services. As mentioned above, documented immigrants often cannot afford or are not offered employer based health insurance. However, prior to PRWORA, the eligibility rules for Medicaid and SCHIP equally applied to citizens and documented immigrants.[25] The law, however, arbitrarily

18. *Id.*
19. *Id.* at ii.
20. *Id.* at 14.
21. *Id* at 9.
22. FREMSTAD & COX, *supra* note 17, at 15.
23. *Id.*
24. The term "natives" is used in this article to refer to those citizens who are born in the United States.
25. BRODER, *supra* note 15, at 4.

prohibits documented immigrants that entered the United States on or after August 22, 1996 from accessing these programs for five years.[26]

Documented immigrants subject to the five-year ban may apply for state-funded programs, if available. The majority of these programs have the same or similar scope and coverage rules as Medicaid and SCHIP, and some states restrict coverage to a limited category of immigrants.[27] As a result, non-citizens under the five-year ban who do not have access to state funded programs are limited to the resources available to undocumented immigrants described above.

## IV. ADDITIONAL BARRIERS TO IMMIGRANTS WHO ARE ELIGIBLE FOR MEDICAID AND SCHIP

There are many documented immigrants and child-citizens who are eligible for Medicaid and SCHIP but continue to face enrollment barriers. Immigrant families must contend with the service issues common to all low-income patients, such as the availability of care at convenient hours for working parents, transportation, and child care.[28] In addition, under PRWORA, "qualified" immigrants must present documentation of their immigration status to qualify for Medicaid, which the Immigration and Naturalization Service ("INS") must then verify.[29] As a result, even though this law allows health coverage for "qualified" immigrants, immigrant communities do not take advantage of this benefit because there is a great deal of confusion regarding eligibility requirements.

For example, the Deficit Reduction Act of 2005 ("DRA")[30] contains a provision requiring Medicaid applicants to provide additional documentation to verify citizenship or legal immigration status prior to obtaining Medicaid benefits.[31] Specifically, the DRA requires "(1) a passport or other government-issued certification of citizenship or nationality or (2) a U.S. birth certificate or equivalent document plus additional proof of identity."[32] The purpose of the DRA was to prohibit ineligible immigrants from receiving Medicaid benefits; however, the DRA has also prevented eligible low-income eligible applicants who do not have access to this documentation from enrolling in Medicaid because they lack

26. FREMSTAD & COX, *supra* note 17, at 10.

27. *Id.*

28. *Id.* at 27.

29. Jacob Press, Comment, *Poor Law: The Deficit Reduction Act's Citizenship Documentation Requirement for Medicaid Eligibility*, 8 U. PA. J. CONST. L. 1033, 1037 (2006).

30. Deficit Reduction Act of 2005, Pub. L. No. 109-171, § 6036, 120 Stat. 4, 171 (2006).

31. Press, *supra* note 29, at 1033.

32. *Id.* at 1038.

the required documentation.[33] From July 31, 2006 to March 1, 2007, 19,413 eligible individuals in Wisconsin were either denied or lost Medicaid coverage as a result of the DRA documentation requirement.[34] This phenomenon has had a chilling effect on immigrant enrollment, even though immigrant eligibility requirements have remained unchanged.[35]

Many immigrants also face significant linguistic barriers in accessing health care. More than forty-six million Americans do not speak English at home.[36] Although many of these individuals are bilingual, approximately twenty-one million have limited English proficiency ("LEP").[37] Therefore, LEP Medicaid or SCHIP candidates cannot effectively apply for benefits or communicate with healthcare providers without language assistance.[38] Under Title VI of the Civil Rights Act of 1964, recipients of federal funding are required to provide reasonable language assistance to individuals with LEP; however, recipients' compliance with this obligation is limited.[39] On the other hand, some states have gone a step further and require local Medicaid offices to hire bilingual workers and implement programs designed to ensure quality oral and written interpretations.[40] For example, Washington State requires the hiring of bilingual case workers when the number of LEP candidates reaches a specified level.[41] The state also provides automatic translation of all written notices and major written communication in the seven most commonly encountered languages.[42]

Yet, even if enrolled, these families may continue to face barriers in the receipt of medical services.[43] In addition to contending with the services issues common to all low-income patients, immigrants must also overcome language barriers that may impede access to health or diminish quality of care.[44]

Immigrants may also fear that enrolling in Medicaid or SCHIP may result in them being classified as a public charge. A public charge designation occurs where an immigrant is dependant on government

33. *See id.* at 1040.

34. DONNA COHEN ROSS, CTR. ON BUDGET POLICY & PRIORITIES, NEW MEDICAID CITIZENSHIP DOCUMENTATION IS TAKING A TOLL: STATES REPORT ENROLLMENT IS DOWN AND ADMINISTRATIVE COSTS ARE UP 4 (2007), http://www.cbpp.org/2-2-07health.pdf.

35. *See* BRODER, *supra* note 15, at 8.

36. Rose Cuison Villazor, *Increasing Access to Health Care: Methods to Address the National Crises*, 8 N.Y.U. J. LEGIS. & PUB. POL'Y 35, 41 (2004-05).

37. *Id.*

38. BRODER, *supra* note 15, at 7.

39. *Id.*

40. FREMSTAD & COX, *supra* note 17, at 23.

41. *Id.* at 24.

42. *Id.*

43. *Id.* at 27.

44. *Id.*

benefits for her long-term economic support.[45] Current immigration law allows officials to deny applications for permanent residency if the authorities find the intending immigrant is "likely to become a public charge."[46]

Shortly after enactment of PRWORA, which did not change the law on public charge, immigration officials and judges began to prevent immigrants from reentering the United States or obtaining Legal Permanent Resident status and demanded immigrants repay benefits like Medicaid and withdrew from public benefit programs.[47] As a result, in 1999, INS issued guidance that the receipt of health care and other non-cash benefits will not be a factor in a public charge determination.[48]

Similarly, immigrants fear that if they apply for public health insurance, the administrative agency will report the immigrant's documentation status to the Department of Homeland Security.[49] Some benefit agencies, such as Medicaid, have misinterpreted rules requiring them to verify immigration and citizenship status of applicants; these agencies thus allow agency personnel to act as immigration enforcers.[50] Under PRWORA, agency personnel are only to report applicants who apply to SSI, public housing, and TANF whom the agency knows are not lawfully residing in the United States.[51]

Not surprisingly, there remains a great deal of fear and confusion in the immigrant community regarding the eligibility, availability, and ramifications of applying for public health benefits.[52] As a result, many immigrant families are reluctant to seek health services for fear of jeopardizing their immigration status.[53] The rules governing immigrant eligibility for public benefits are undeniably complex. They vary by state, immigration status, and for many immigrants, by the date of entry into the United States. In addition, families may be comprised of members whose immigration statuses differ, further complicating the issue of eligibility. Fortunately, studies have shown that aggressive outreach for targeted populations has increased enrollment in Medicaid and SCHIP.[54] For

45. FREMSTAD & COX, *supra* note 17, at 24.

46. Joan Friedland and Tanya Broder, *Immigrant Benefits and Documentation Issues*, 1390 PRAC. L. INST./CORP. L. & PRAC. COURSE HANDBOOK SERIES 187, 204 (2003).

47. *Id.*

48. *Id.*

49. BRODER, *supra* note 15, at 9.

50. *Id.* at 8.

51. *Id.* at 9.

52. *See* FREMSTAD & COX, *supra* note 17, at 24.

53. ANNE MORSE, THE NAT'L CONFERENCE OF STATE LEGISLATURES, SCHIP AND ACCESS FOR CHILDREN IN IMMIGRANT FAMILIES (2005), http://www.ncsl.org/programs/health/forum/pub6682.htm.

54. *See generally* KAISER COMM'N ON MEDICAID & THE UNINSURED, OUTREACH

example, the Illinois Department of Human Services provided funding to a collection of thirty-four organizations serving immigrants families, known as the Outreach and Interpretation Project.[55] These organizations provided immigrant families information regarding the availability of public benefits, case management services, translations services, and assistance in completing application forms.[56] Although there is a great deal of work to be done, community-based efforts and state-wide advertising have proven to be effective in increasing enrollment, including immigrant enrollment, in public health insurance programs.[57]

## V. CONCLUSION

Documented and undocumented immigrants face many barriers in accessing health care in the United States. Although undocumented immigrants face the greatest challenge in gaining access to public health insurance, documented immigrants face many of the same challenges if they are under the five-year ban for Medicaid. In addition, immigrants eligible for public health insurance still struggle with language barriers, confusion regarding eligibility requirements, and fear that applying for these programs may affect their immigration status. These problems make clarity and simplification necessary in the eligibility and renewal process.

In the following transcript, Ms. Ambegoakar highlights the numerous barriers and speaks to the realities of immigrant access to health care.

STRATEGIES FOR MEDICAID AND SCHIP: AN OVERVIEW OF EFFECTIVE STRATEGIES AND ACTIVITIES 15 (2006), http://www.childrensdefense.org/site/DocServer/OutreachStrategiesMedicaidCHIP.pdf?docID=5621.

55. FREMSTAD & COX, *supra* note 17, at 22.

56. *Id.*

57. *Id.* at 29.