

**Immigrants, Refugees, Asylees, and the Undocumented: Understanding Laws that Impact Their Health and Well-Being.**

Immigrants and their families are more likely to go without health care coverage, public or private, deeply impacting their ability to obtain critical health care services. Like many American families, the primary reason that many immigrants are uninsured is the lack of available employment-based health care coverage.<sup>1</sup> However, immigrant households also face greater difficulty accessing high-quality preventive care and treatment and other health services because of legal restrictions to federal programs and confusion about eligibility, which is exacerbated by a lack of available linguistically- and culturally-appropriate services.

In 1996, the Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA, P.L. 104-193) was passed, enacting a number of federal budget savings measures that fell on the backs of noncitizen immigrants. The majority of lawfully-present immigrants are now subject to multiple barriers which affect access to federal “means-tested” public benefits. Even if otherwise qualified, an immigrant arriving after August 22, 1996, the date of enactment of PRWORA, is prohibited from accessing Medicaid and the State Children’s Health Insurance Program (SCHIP) for the first five years of residence in the U.S. After the five-year bar, there are many other documentation and verification requirements that serve as deterrents to health care safety-net programs for many immigrant households.

Immigrants are further hindered from accessing health care because of language barriers which prevent their enrollment into – and most effective use of – services. For instance, Latinos – who represent a large percentage of the foreign-born – report that they are less likely to be covered by health insurance if they are Spanish-language dominant.<sup>2</sup> During the enrollment process for health insurance and other coverage, persons with limited English proficiency (LEP) often are mistaken as ineligible due to communication difficulties. Further, language limitations can ultimately frustrate immigrants and prevent them from completing the application processes. More than four in ten (46%) Spanish-speaking parents noted that they did not enroll eligible children into Medicaid, simply because they thought that materials in their language were unavailable. Further, half were discouraged from applying for Medicaid due to the lack of language services.<sup>3</sup>

Even when covered by health insurance, the quality of care that they receive can also be deeply affected by language barriers. Although 63% of hospitals see patients with limited English proficiency on a daily or weekly basis, there continues to be a lack of resources provided by the government and other entities which would ensure effective communication in health care settings.<sup>4</sup> More than four in ten Latino immigrants report that they have difficulty communicating with health care providers because of language barriers.<sup>5</sup> These findings are important, because positive health care outcomes increase when patients have access to language services. Patients who receive health care in their primary language are more likely than their counterparts who do not receive translation and interpretation services to follow their prescribed medical regimens, use more preventive health care services, and report high satisfaction.<sup>6</sup>

There are numerous laws and regulations which provide that patients who are immigrant or LEP have access to language services, regardless of immigration status. At the federal level, the Civil

## Jennifer Ng'andu, National Council of La Raza

Rights Act of 1964 (P.L. 88-352) prohibits discrimination of persons based on national origin. Further, Presidential Executive Order 13166 provides that entities receiving federal funding take steps to provide meaningful access to language services for persons who are LEP or risk the loss of funding.

The barriers that immigrants face in obtaining health care services also affect their families. Most immigrant families are of mixed status, meaning that at least one family member, often a child, is a citizen and one member is a noncitizen. In fact, among families in which at least one parent is undocumented, the Pew Hispanic Center estimates that at least 64% of those children are citizens.<sup>7</sup> Many immigrants are confused by current laws and often fear that the use of benefits by eligible family members puts them at risk for family separation or deportation, or will hurt their chances of becoming a permanent resident or citizen. For instance, the requirement that the use of certain federal public benefits be reported to the U.S. Citizenship and Immigration Services (CIS) has created great fear of immigration consequences in immigrant and Hispanic communities, even though the requirement does not apply to Medicaid and SCHIP, the primary federal health insurance programs that low-income Americans access.

Finally, recent laws perpetuated by myths that undocumented immigrants are abusing federal programs and the anti-immigrant sentiment that has increased since the debate on immigration reform developed have fueled this fear in immigrant communities and in some instances created deeper restrictions concerning health care. In the Medicare Modernization Act of 2003 (P.L. 108-173), the U.S. Congress passed a provision often referred to as Section 1011, which provided \$250 million for four fiscal years for purposes of reimbursing hospitals for uncompensated emergency care treatment of undocumented immigrants, persons with border crossing cards, i.e., “laser visas,” and persons paroled into the U.S. for purposes of medical treatment. As part of the implementation of the law, the Centers for Medicare and Medicaid Services (CMS) required that health care providers employ an indirect, but highly invasive, questioning methodology to determine a patient’s immigration or citizenship status. The result is that most of the funding has gone unused. For instance, in Virginia, which has more than \$2.8 million available for reimbursement, health care providers have only requested \$530,000 in reimbursement, of which approximately 20% of reimbursements were granted.<sup>8</sup> Anecdotally, there is evidence of a reluctance of both health care providers and patients to engage in the deep questioning that is required by this new proposal, which could possibly put patients at risk for immigration enforcement and has resulted in heavy administrative burdens for providers. Another more recently passed proposal is the Deficit Reduction Act of 2005 (P.L. 109-171), which requires that all citizens provide a heavy set of documentation in order to qualify for Medicaid. *The Washington Post* recently reported that “thousands of low-income children have been unable to enroll in Virginia's Medicaid program,” because of the increased documentation requirements.<sup>9</sup> However, since the law was pushed forward as an attempt to restrict immigrant access to Medicaid, the implications have been felt by Medicaid applicants and “eligibles” who are citizens and noncitizens alike.

The integration of legal restrictions, language barriers, and confusion and fear has resulted in lower health care utilization rates by immigrant-headed households. A 2005 study in the *American Journal of Public Health* analyzing data from the Medical Expenditure Panel Survey (MEPS) found that per capita expenditures on health care services were lower for immigrants.

## Jennifer Ng'andu, National Council of La Raza

Health care expenditures on immigrants were less than half that of U.S.-born citizens (\$2,546 per capita for U.S.-born citizens versus \$1,139 per capita for immigrants), including those that were publicly-funded.<sup>10</sup> Further, emergency room visits are lower among immigrants, a particularly interesting finding, since emergency care is one of the few health care options available to all persons living in the U.S. regardless of immigration or citizenship status. A recent *Health Affairs* article noted that only 6.3% of noncitizens used hospital emergency services in 2003, compared to 31.8% of citizens, despite higher uninsurance rates.<sup>11</sup> Immigrants' emergency care costs were about one-third of U.S.-born citizens (\$33 versus \$91, respectively, per capita).

It is commonly perceived that immigrants, particularly those arriving recently, experience a "health paradox" in which they are healthier than their U.S.-born counterparts, despite limited access to health care. However, this train of thought threatens the future health status of immigrant households. While many noncitizens may be in good health status themselves, the lack of access to health care often manifests in the bodies of their young children.<sup>12</sup> Immigrant parents are more likely to report that their children are in "fair" or "poor" health compared to the children in citizen-headed households. Further, by assuming that this population is healthy, and in continuing to eliminate health coverage options for immigrants, the public health implications of shutting a significant population out of the health care system are ignored. Shoring up policies which ensure access to health care programs, improving linguistically-appropriate outreach, and ensuring proper training of the health care workforce are all necessary actions to ensuring that immigrants are fully integrated into the health care system and that their opportunities to succeed are secured.

---

<sup>1</sup> Alker, Joan C. and Jennifer Ng'andu, *The Role of Employer-Sponsored Health Coverage for Immigrants: A Primer*. Washington, DC: Kaiser Commission on Medicaid and the Uninsured and the National Council of La Raza, June 2006.

<sup>2</sup> *Health Care Experiences – 2002 National Survey of Latino Experiences*. Washington, DC: Pew Hispanic Center and Henry J. Kaiser Family Foundation, March 2004.

<sup>3</sup> *Medicaid and Children: Overcoming Barriers to Enrollment*. Washington, DC: Kaiser Commission on Medicaid and the Uninsured. July 2000.

<sup>4</sup> Hasnain-Wynia, Romana, Julie Yonek, Debra Pierce, Ray Kang, and Cynthia Hedges Greising, *Hospital Language Services for Patients with Limited English Proficiency: Results from a National Survey*. Chicago, IL: Health Research and Education Trust, October 2006.

<sup>5</sup> *Health Care Experiences – 2002 National Survey of Latino Experiences, op. cit.*

<sup>6</sup> Ku, Leighton and Timothy Waidman, *How Race, Ethnicity, Immigration Status, and Language Access Affect Health Insurance Coverage, Access to Care and Quality of Care Among the Low-Income Population*. Washington, DC: Kaiser Commission on Medicaid and the Uninsured, August 2003; Jacobs, E.A., D.S. Lauderdale, D. Meltzer, J.M. Shorey, W. Levinson, and R.A. Thisted. "The Impact of Interpreter Services on Delivery of Care to Limited-English-Proficient Patients," *Journal of General Internal Medicine*, Vol. 16, No. 7, 2001, pp. 468-474; Sarver, Joshua and David W. Baker, "Effect of Language Barriers on Follow-up Appointments After an Emergency Department Visit," *Journal of General Internal Medicine*, Vol. 15, No. 4, April 2000, pp. 256-264; Rivadeneyra R., V. Elderkin-Thompson, R.C. Silver, and H. Waitzkin, "Patient Centeredness in Medical Encounters Requiring an Interpreter," *American Journal of Medicine*, Vol. 108, No. 6, 2000, pp. 470-474; Baker, D. W., R. Hayes, and J. P. Fortier, "Interpreter Use and Satisfaction with Interpersonal Aspects of Care for Spanish-Speaking Patients," *Medical Care*, Vol. 36, No. 10, 1998, pp. 1461-1470

<sup>7</sup> Passel, Jeffrey S., *The Size and Characteristics of the Unauthorized Migrant Population in the U.S.* Washington, DC: Pew Hispanic Center, March 7, 2006.

<sup>8</sup> Preliminary figures provided by the Centers for Medicare and Medicaid Services (CMS).

<sup>9</sup> "Rules Deter Poor Children From Enrolling in Medicaid," *The Washington Post*, Oct. 8, 2006.

## Jennifer Ng'andu, National Council of La Raza

---

<sup>10</sup> Mohanty, Sarita, Steffie Woolhandler, David U. Himmelstein, Susmita Pati, Olveen Carrasquillo, and David H. Bor, "Health Care Expenditures of Immigrants in the United States: A Nationally Representative Analysis," *American Journal of Public Health*, Vol. 95, No. 8, August 2005, pp. 1431-1438.

<sup>11</sup> Cunningham, Peter J., "What Accounts for Differences in the Use of Hospital Emergency Departments Across U.S. Communities?" *Health Affairs*, Vol. 25, July 18, 2006, pp. 324-336.

<sup>12</sup> Capps, Randolph, Michael E. Fix, Jason Ost, Jane Reardon-Anderson, and Jeffrey S. Passel, *The Health and Well-Being of Young Children of Immigrants*. Washington, DC: The Urban Institute, February 8, 2005.