



# On The Path Toward Health for All:

Opportunities for States to Expand Public  
Coverage to Immigrants Using Federal Funds [▶](#)

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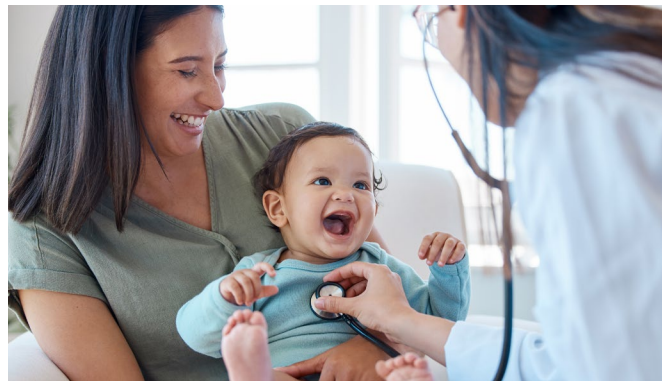
By Gabrielle Lessard | December 2023



This is part **two** of a series of policy briefs explaining different tools available to states to achieve Health for All – access to quality, affordable health coverage for all state residents, regardless of immigration status.

## Overview

Federal policies limiting immigrants' access to health coverage have compromised individual and public health. To improve health equity, health outcomes, and public health in their communities, states have begun enacting policies that expand access to affordable health coverage to some or all immigrants. This brief focuses on how states can leverage federal funds to cover certain populations through their public health insurance programs. States can exercise certain options to provide coverage to lawfully residing children, lawfully residing pregnant people or both groups, as well as to provide care to pregnant individuals regardless of their immigration status.



Restrictive federal policies adopted during the 1990s make many immigrants, including many who are lawfully present, ineligible for essential health services through Medicaid and the Children's Health Insurance Program (CHIP). The source of these policies, the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA), also known as the welfare law,<sup>1</sup> created a system of exclusion that left immigrants disproportionately uninsured, as compared to the U.S. born.

But thanks to advocacy at the federal level—combined with leadership in the states—PRWORA was not the final word. Stakeholders, including the National Immigration Law Center, helped secure a change in federal law that allows states the option to cover more immigrant children and pregnant people, and importantly to receive some federal funding to do so. The successful take-up of these options across the country demonstrates that expanding coverage can be a popular policy choice. Importantly, expanding access under these federal options helps states pave the way toward Health for All.

A key component of any expansion of health coverage is finding a way to pay for it. States can begin by maximizing access to federal funding for coverage, as states across the political spectrum have done. Advocates in the [minority of states](#) that have not yet exercised these options have a significant opportunity to persuade state policymakers to adopt them as common sense, cost-effective vehicles for reducing the state's uninsured population and improving health outcomes.

## The Problem: PRWORA's Restrictions Excluded Immigrants from Access to Health Coverage and Other Essential Services

Before PRWORA went into effect, "lawfully present" immigrants generally were eligible for public benefits on the same terms as U.S. citizens.

PRWORA created a distinction between lawfully present immigrants who were considered "qualified" for federal benefits purposes and those who were not, despite being lawfully present in the United States.<sup>2</sup> Lawfully present individuals who are "qualified" include lawful permanent residents (LPRs), also referred to as green card holders. The qualified immigrant classification also includes refugees, persons granted asylum, Cuban/Haitian entrants, persons paroled into the U.S. for at least one year, certain survivors of domestic violence or trafficking, and others. Persons who entered the U.S. under a treaty called the Compact of Free Association (COFA) are considered "qualified" immigrants for Medicaid purposes only.

There are numerous categories of lawfully present immigrants who are not considered qualified for benefits purposes, such as people granted deferred action, Temporary Protected Status (people in the U.S. who cannot safely return to their home countries because of natural disasters, ongoing armed conflict, or other circumstances), children and youth with Special Immigrant Juvenile Status, and survivors of serious crimes granted U nonimmigrant status. These individuals are not eligible for many federal public benefit programs unless they are able to obtain a green card or another "qualified" immigrant status.

Pursuant to PRWORA, only qualified immigrants are eligible for certain federal public benefit programs, and many qualified immigrants are also subject to a five-year or longer waiting period in five major programs (Medicaid, CHIP, TANF, SNAP and SSI).<sup>3</sup> "Not qualified" immigrants generally are excluded from federal public benefit programs, including Medicaid and CHIP, with the exception of Medicaid used for treating emergency medical conditions.<sup>4</sup>

## The Evidence: The Importance of Coverage During Childhood and Pregnancy

A significant body of research demonstrates that access to health coverage during childhood and pregnancy is particularly important and improves outcomes.

Having health coverage during childhood has lasting effects on long-term health outcomes. Children covered by Medicaid in early childhood have been shown to have fewer mental health issues, better health, and to be less likely to engage in harmful behaviors such as smoking in adolescence.<sup>5</sup> The positive effects of childhood Medicaid enrollment continue into adulthood, with one study finding a lower likelihood of high blood pressure, heart



disease/heart attack, adult-onset diabetes, and obesity among adults aged 25 to 54 who had been covered by Medicaid as children.<sup>6</sup>

Childhood Medicaid coverage also prepares children to make future economic contributions. One study showed that access to Medicaid during childhood improved educational outcomes and led to higher educational attainment, including higher rates of college attendance and degree completion.<sup>7</sup> Researchers who analyzed tax data found that each additional year of Medicaid coverage during childhood resulted in decreased teen births and increased adult wages and tax payments. Researchers also found that childhood Medicaid coverage decreased the likelihood that the recipient would receive the Earned Income Tax Credit as an adult.<sup>8</sup>



Children born to parents who received prenatal care through Medicaid also had improved adult health outcomes. These included lower rates of obesity, fewer preventable hospitalizations, and fewer hospitalizations related to immune-system disorders and endocrine, nutritional, and metabolic diseases. They also had higher rates of high school completion.<sup>9</sup>

Although less information is available about the effects of prenatal care on adults, what is available is similarly supportive. A recent study found statistically significant reductions in depression among parents who had received Medicaid-funded prenatal care.<sup>10</sup> A study of California's expansion of Medicaid coverage to pregnant adults, regardless of immigration status, found reductions in pre-term and low-weight births, as well as significant reductions in complications experienced during pregnancy.<sup>11</sup>

## **The Solution: Policy Options to Cover Immigrant Children and Pregnant People**

### **Coverage for Lawfully Residing Children and Pregnant Individuals**

Congress expanded access to health care for many children when it created the Children's Health Insurance Program (CHIP) in 1997. As initially enacted, CHIP restricted eligibility for immigrant children who were not "qualified" and imposed a five-year waiting period for most children who were "qualified." However, unlike Medicaid, CHIP requires periodic reauthorization, which creates opportunities to revisit its parameters.<sup>12</sup> When Congress reauthorized CHIP in 2009, it included provisions that allow states to opt into covering lawfully residing children and/or lawfully residing pregnant individuals in their Medicaid and CHIP programs, without a waiting period.<sup>13</sup> The term "lawfully residing" in this context means that the individual is both lawfully present under CHIP guidelines and a state resident under Medicaid policies.<sup>14</sup>

The CHIP provision is not a mandate, but an option which allows states to draw down federal matching funds to cover individuals who would otherwise be ineligible for a federal match. States can elect to cover either pregnant individuals, children, or both groups, and can choose to cover them in Medicaid only or in Medicaid and CHIP, but

not CHIP alone.<sup>15</sup> Children's coverage may extend to age 21, although states can opt to terminate eligibility at age 19 or 20. Pregnancy coverage includes a 60-day period after the end of the pregnancy, although a 2021 law called the American Rescue Plan Act allows states to opt into extending post-partum coverage to a full year for individuals covered by their Medicaid and CHIP programs during pregnancy.<sup>16</sup>

## Prenatal Coverage Regardless of Immigration Status

In 2002, the Centers for Medicare and Medicaid Services (CMS) amended the CHIP regulations to define a child as "an individual under the age of 19 including the period from conception to birth," which made it easier for states to provide prenatal services through CHIP.<sup>17</sup> Under the reasoning of the drafters, since the fetus or 'child' is the CHIP recipient and does not have an immigration status, the services are available regardless of the pregnant individual's immigration status.<sup>18</sup> Regardless of where stakeholders or states stand on the issues underlying this rationale, states across the political spectrum can and have elected to provide prenatal services regardless of immigration status by amending their CHIP state plans.<sup>19</sup>

## What States Should Do

States exercise these policy options by submitting state plan amendments to CMS.<sup>20</sup> Whether a state plan amendment requires legislative approval depends on the individual state's policy.



**Medicaid and the Children's Health Insurance Program (CHIP)** operate as a partnership between states and the federal government, specifically the Centers for Medicare and Medicaid Services (CMS). While federal law provides the framework for the two programs, states have some flexibility in implementation. State Plan documents are agreements between CMS and a state that detail how the state will operate its Medicaid and CHIP programs.

State plans are amended over time as policies change. A description of the process is here: <https://www.macpac.gov/subtopic/state-plan/>

States are required to indicate the expected federal financial impact of proposed state plan amendments, but there are no budget neutrality requirements.

## Learning from State Campaigns: Arkansas

By Isobel Mohyeddin

A coalition of Arkansas advocates, including health care providers, schools, members of immigrant communities and other allies, worked for seven years to persuade their state to exercise the option to cover lawfully residing children in the state's CHIP program, ARKids First. A focal point for their advocacy was the state's high number of children born in the Marshall Islands.

Starting in 2010, advocates wrote op-eds, gave speeches, and made a concerted effort to raise awareness of the opportunity to increase coverage for kids, directing their efforts to a then-Democratic governor and bipartisan legislature. However, the Great Recession forced the governor to look for ways to trim the state budget.

Two factors set the stage for success in 2017. The Affordable Care Act included a temporary increase in the rate of federal CHIP matching funds available to states. Some states, including Arkansas, received a 100% match, which enabled the state to implement the program at minimal cost. In addition, a legislative champion emerged: State Representative Jeff Williams, a newly elected Republican legislator from a district with a high proportion of immigrant families, including many members of the Marshallese community. While no legislation was required to adopt the expansion in Arkansas, Rep. Williams sponsored a resolution that encouraged the Governor and his administration to exercise the lawfully present CHIP option. In March of 2017, Republican Governor Asa Hutchinson signed the legislative resolution asking the state to adopt a state plan amendment to cover lawfully residing children and pregnant individuals.

"We want all children, regardless of immigration status, to have access to ARKids First and programs like it," shared Laura Kellams from Arkansas Advocates for Children and Families. "In a state like Arkansas, that isn't likely to happen anytime soon. But this was a feasible step we could take here that has made a huge difference."<sup>21</sup>

## Conclusion

Using options under Medicaid and CHIP to cover additional groups of immigrants is the first step that a state can take toward Health for All, and for good reason: states can draw down federal funding. Since Medicaid and CHIP are paid for by a mix of federal and state funds, states can expand eligibility for targeted populations at nominal cost while delivering significant public benefits. The individuals who would receive coverage under the options described in this paper already are eligible for expensive emergency services, including labor and delivery, through emergency Medicaid, so states do not need to factor these services into the cost of adopting these options. The marginal cost of adding a more complete set of services is low, particularly with federal matching funds.<sup>22</sup>

Adopting these policy options is also an investment in community success. As researchers have demonstrated, this coverage has a dramatic impact on both the short- and long-term health of individuals, as well as their economic and intangible contributions to their community.

There's no reason for states to wait. Advocates in places that have not exercised these options should partner with their Medicaid and CHIP agencies or state legislatures to prioritize this important policy solution. Even if Health for All seems out of reach at the moment, these policies can have a concrete positive effect on immigrants and communities.

# Endnotes

1. Public Law 104-193. PRWORA's immigrant eligibility restrictions are codified at 8 USC §1611.
2. 8 USC §1641.
3. See Tanya Broder and Gabrielle Lessard, "Overview of Immigrant Eligibility for Federal Benefit Programs" (National Immigration Law Center, updated October 2023), <https://www.nilc.org/issues/economic-support/overview-immeligfedprograms>
4. An emergency medical condition is defined at 42 USC §1396b(v)(3) as:  
a medical condition (including emergency labor and delivery) manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in—
  - (A) placing the patient's health in serious jeopardy,
  - (B) serious impairment to bodily functions, or
  - (C) serious dysfunction of any bodily organ or part.
5. Sarah Cohodes, Samuel Kleiner, Michael F. Lovenheim, Daniel Grossman, "The Effect of Child Health Expansions on Schooling: Evidence from Public Insurance Expansions", NBER Working Paper 20178 (National Bureau of Economic Research, May 2014), <https://www.nber.org/papers/w20178>
6. David Murphey, Research Brief: Health Insurance Coverage Improves Child Well-Being (Child Trends, May 2017), [https://cms.childtrends.org/wp-content/uploads/2017/05/2017-22HealthInsurance\\_finalupdate.pdf](https://cms.childtrends.org/wp-content/uploads/2017/05/2017-22HealthInsurance_finalupdate.pdf)
7. Sarah Cohodes, Samuel Kleiner, Michael F. Lovenheim, Daniel Grossman, "The Effect of Child Health Expansions on Schooling: Evidence from Public Insurance Expansions", NBER Working Paper 20178 (National Bureau of Economic Research, May 2014), <https://www.nber.org/papers/w20178>
8. David W. Brown, Amanda E. Kowalski and Ithai Z. Lurie, "Long-Term Impacts of Childhood Medicaid Expansions on Outcomes in Adulthood", *Rev Econ Stud.* 2020 Mar; 87(2): 792–821, <https://academic.oup.com/restud/article/87/2/792/5538992>
9. Sarah Miller and Laura R. Wherry, "The Long-Term Effects of Early Life Medicaid Coverage", August 25, 2016, available at SSRN, <https://dx.doi.org/10.2139/ssrn.2466691>
10. Melanie Guldi and Sarah Hamersma, "The effects of pregnancy-related Medicaid expansions on maternal, infant, and child health", *87 Journal of Health Economics* 102695 (2023). <https://pubmed.ncbi.nlm.nih.gov/36502571/>
11. Sarah Miller and Laura Wherry, "Covering Undocumented Immigrants: The Effects of a Large-Scale Prenatal Care Intervention", NBER Working Papers 30299, (National Bureau of Economic Research, Inc., 2022), <https://www.nber.org/papers/w30299>
12. The option is often called "CHIPRA" because it was made available through the CHIP Reauthorization Act. See CHIP Permanent: It's a Matter of Fairness (First Focus on Children, March 1, 2023), <https://firstfocus.org/resources/fact-sheet/chip-permanent-its-a-matter-of-fairness>
13. 42 USC 42 USC §1396b(v)(4).

14. "Lawfully Residing" Children and Pregnant Women Eligible for Medicaid and CHIP (National Immigration Law Center, revised October 2021), <https://www.nilc.org/issues/health-care/lawfully-residing-medicaid-chip/>
15. SHO #10-006, Letter from Cindy Mann to State Health Officials, July 1, 2010, available at <https://downloads.cms.gov/cmsgov/archived-downloads/SMDL/downloads/SHO10006.pdf>
16. The option for full-year post-partum coverage is currently scheduled to sunset on April 1, 2027. See, Usha Ranji, Alina Salganicoff, and Ivette Gomez, Postpartum Coverage Extension in the American Rescue Plan Act of 2021 (Kaiser Family Foundation, March 18, 2021), <https://www.kff.org/policy-watch/postpartum-coverage-extension-in-the-american-rescue-plan-act-of-2021/>
17. 42 CFR §457.10.
18. See 67 Fed. Reg. 61956 (October 2, 2002). The discussion of immigration status begins at page 61965. <https://www.govinfo.gov/content/pkg/FR-2002-10-02/pdf/02-24856.pdf>. This option does not provide post-partum coverage, however some states have used their own funds or limited federal matching funds available through CHIP Health Services Initiatives to provide post-partum care. See State-Funded Health Coverage for Immigrants as of July 2023, (Kaiser Family Foundation, July 26, 2023), <https://www.kff.org/racial-equity-and-health-policy/fact-sheet/state-funded-health-coverage-for-immigrants-as-of-july-2023/>
19. SHO #02-004, Letter from Dennis G. Smith to State Health Officials, November 12, 2002, available at [https://healthlaw.org/wp-content/uploads/2018/09/cms\\_release\\_on\\_prenatal\\_care\\_for\\_fetuses.pdf](https://healthlaw.org/wp-content/uploads/2018/09/cms_release_on_prenatal_care_for_fetuses.pdf)
20. Some states have instead used state funding to provide these services. See Medical Assistance Programs for Immigrants in Various States (National Immigration Law Center, August 2023), <https://www.nilc.org/issues/health-care/medical-assistance-various-states/>
21. Kellams, Laura. Interview. Conducted by Isobel Mohyeddin. August 17, 2023
22. See Laurel Lucia, Ken Jacobs, Dave Graham-Squire, Greg Watson, Dylan H. Roby, Nadereh Pourat, and Gerald F. Kominski, "A Little Investment Goes a Long Way: Modest Cost to Expand Preventive and Routine Health Services to All Low-Income Californians" (UC Berkeley Center for Labor Research and Education and UCLA Center for Health Policy Research, May 2014), [https://laborcenter.berkeley.edu/pdf/2014/health\\_undocumented.pdf](https://laborcenter.berkeley.edu/pdf/2014/health_undocumented.pdf)