Closing the Gap

Why Immigrant Children Must Have Access to Health Care – and How to Get There

April 2013

Children's Health Fund

This report was prepared by the Children's Health Fund, an organization committed to providing comprehensive health care to the nation's most medically underserved children through the development and support of innovative primary care medical programs and the promotion of guaranteed access to appropriate health care for all children. To learn more, visit http://www.childrenshealthfund.org/

We would like to acknowledge the core group of individuals who made this report possible. At the Children's Health Fund, this work was a collaboration among CHF President Dr. Irwin Redlener, Executive Vice President Dennis Johnson, Chief Medical Officer and Senior Vice President for Medical Affairs Dr. Delaney Gracy, Senior Director of Policy and Advocacy Caroline DeRosa, Director of Applied Research and Academic Publications Roy Grant, and Senior Policy and Program and Research Analyst Morissa Sobelson. In addition, we thank Dr. Shaanan Meyerstein, Resident in Pediatrics at North Shore-Long Island Jewish Schneider Children's Hospital, for his research and writing contributions.

The Children's Health Fund would also like to thank Jenny Rejeske, Health Policy Analyst at the National Immigration Law Center for providing expert review and feedback on the immigration issues discussed in this report.

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Introduction

The Patient Protection and Affordable Care Act (ACA) was signed into law on March 23, 2010 in part to address the health needs of children. The intent of the legislation was to reduce the number of uninsured Americans, improve quality of and access to care, and reduce overall cost of health care services. Although the law is predicted to bring the number of uninsured children to an unprecedented low in the United States, some children will remain among the ranks of the uninsured for a number of reasons. Non-citizen immigrant children will make up the largest single group of uninsured children after the ACA is fully implemented in 2014.[1]

Having early and consistent access to comprehensive care is not only essential to overall well-being for all young people but it is also highly cost-effective. Children with insurance coverage are more likely to utilize preventive health care services and have illnesses treated by a health professional before they develop into more serious and costly problems. In addition, child health coverage is less expensive than adult coverage. Pediatric health interventions, such as asthma care and vaccinations, have the potential to reduce public health care costs in both the short and long term.

The ACA will certainly advance the goal of providing better health care access to millions more children and their families. However, what should amount to widespread restructuring and improvement of the health care system that would extend health coverage to all children has resulted in a system that will allow for the exclusion of millions of immigrant kids. Whether it is done explicitly through laws excluding unauthorized children from public benefits, or implicitly through policies that erect insurmountable barriers to enrollment in public programs, it is both irresponsible and unjust to exclude children residing in this country from accessing health care due to factors outside of their control.

Moving forward, all kids regardless of their or their families' legal status or country of origin, must have access to timely, continuous and quality health care. If we allow this basic concept to guide national policy efforts, there will be a lifetime of dividends in the form of improved health outcomes and overall well-being, as well as long-term financial savings. Failure to adhere to this principle will not only affect the immediate lives of millions of children in the United States, but ultimately will have major ramifications on a future generation of Americans.

Understanding the Immigrant Child Population in the U.S.

The U.S. government assigns specific nomenclature to immigrants, according to their citizenship and immigration status. "U.S. born" refers to an individual who is a U.S. citizen at birth. The individual was either born in the United States, Puerto Rico or other U.S. territories, or was born elsewhere to parents who are U.S. citizens. "Foreign born" or "immigrant" refers to an individual who is born outside the United States, Puerto Rico, or other U.S. territories and whose parents are not U.S. citizens – this includes both authorized and unauthorized immigrants. The Pew Hispanic Center estimated that in March 2010 there were 40.2 million foreign-born people in the U.S.[2]

*Among the 40.2 million immigrants in the U.S., "**authorized immigrant**" (also known as legal immigrants) refers to a person who is lawfully here, including individuals applying for or granted lawful permanent residence ("green card"); asylees; refugees; individuals with a specific temporary status for study or work; as well as other categories of immigrants. Authorized immigrants include both citizens and non-citizens. "**Unauthorized immigrant**" (also known as an undocumented or illegal immigrant) refers to a foreign-born non-citizen residing in the country who is not an "authorized immigrant." Most in this category either came to the U.S. without valid documentation, or arrived with valid documentation but remained beyond their authorized length of stay.*[3]

There are approximately 11 million unauthorized immigrants in the U.S., representing 28 percent of the foreign-born population. Included in this number are at least 1 million children, who are unauthorized immigrants by virtue of being born outside of the U.S. to parents who are unauthorized immigrants. In addition, approximately 4.5 million children are considered to reside in the U.S. in "mixed status" families. These are children born to at least one unauthorized immigrant parent, but who are themselves citizens by birthright.[4]

Deferred Action for Childhood Arrivals

In addition to the "authorized" and "unauthorized" categories of immigrant children in the U.S., there is a new designation for young people to add to this list. The Deferred Action for Childhood Arrivals ("DACA") program was initiated by President Obama in June 2012 and officially began accepting applications August 15, 2012. It allows young unauthorized immigrants who came to the U.S. as children and have pursued education or military service to apply for a temporary reprieve from deportation for two years at a time. While DACA is a new program, the concept of deferred action is not new; it is a form of prosecutorial discretion granted on a case-by-case basis, enabling an

unauthorized individual to temporarily remain in the U.S. Most commonly, it is granted in cases where the person facing deportation or removal is affected by "sympathetic factors" including age, frailty, abuse, or medical need.[5] A grant of deferred action does not provide a path to lawful permanent resident status or U.S. citizenship.[6]

On August 3, 2012, the U.S. Department of Homeland Security published updated eligibility guidelines for the Deferred Action for Childhood Arrivals program. According to the new guidelines, unauthorized immigrants ages 15 to 30 who arrived in the U.S. before age 16 may qualify for deferred action if:

- ***They have continuously resided in the U.S. since June 15, 2007;***
- ***They were physically present in the U.S. on June 15, 2012;***
- ***They are enrolled in school, have a high school diploma or a GED, or have been honorably discharged from the military or Coast Guard by the time of their application; and***
- ***They have not been convicted of a felony, a significant misdemeanor offense, or three or more other misdemeanors, and do not present a threat to national security or public safety.*** [1]

An estimated 750,000 immigrant children could benefit from DACA designation, since they are under the age of 18 and enrolled in school. In addition, 1 million young adult unauthorized immigrants (ages 18 to 30) who came here as children are anticipated to benefit as well. Since federal officials have stated that only those who are age 15 or older are eligible to file for DACA status, 1.3 million individuals would be eligible immediately, and the remaining children would be eligible in the future, as they reach age 15.[7] However, unlike individuals granted deferred action for other reasons, who may be eligible for certain public health programs, federal guidance has specified that individuals granted deferred action under the DACA process are ineligible for Medicaid and CHIP; they are also banned from the new coverage vehicles established under health reform.[8]

Importance of Consistent, Quality Health Care

For all children, having regular access to comprehensive and coordinated health care is critical to ensuring overall health and well-being, offering them the opportunity to reach their full potential. Since uninsured children often lack a usual source of pediatric care, they are unlikely to receive necessary preventive health services.

Immunizations exemplify the importance of why early access to comprehensive health care services is critical. Childhood vaccines are among the most cost-effective, of all public health interventions. It is estimated that routine childhood vaccination programs save $9.9 billion in medical costs for the babies born in any given year by controlling or eliminating the spread of polio, diphtheria, tetanus, pertussis (whooping cough), hepatitis B, measles, mumps and rubella (German measles) among others diseases. In addition, the public health impact of unimmunized kids should not be underestimated. When immunizations are not adequately available or provided, outbreaks of preventable infectious diseases typically occur. For example, states that have made it easier for parents to opt out of mandatory immunizations had a 90% higher incidence of pertussis in 2011.[9]

Health care access is especially significant for infants and young children, since developmental delay, hearing and vision problems, lead poisoning, anemia, and other health issues require early identification and intervention to prevent compromised development and school performance. For example, a common health problem of early childhood, recurrent ear infections, can lead to chronic hearing and speech-language deficits if untreated; this preventable outcome occurs more than twice as often for uninsured children compared to their insured peers. Similarly, uninsured children are 1.7 times more likely to have untreated asthma, which contributes to preventable emergency department use. Finally, timely care for acute problems and chronic illnesses can have a far-reaching positive impact on a child's overall quality of life. When children have access to care, they are likely to miss fewer days of school and be able to participate in sports and other healthy activities.[10]

"It is humbling to see your ideals or dreams come to fruition."

— Dr. Juan Robles

Providing all children with the opportunity to reach their full potential benefits everyone. It's difficult to imagine a better illustration of this than the story of Juan Robles.

Juan was born in Honduras, and came to the U. S. when he was 13. Having come from a family with little formal education, Juan worked twice as hard to complete junior high school, become valedictorian of his high school class and then gain entry into Cornell University.

A Children's Health Fund patient as a boy, Juan credits his access to quality health care services with inspiring him to become a doctor himself. And today he is one, practicing in the very South Bronx neighborhood where he grew up.

Disparities in Accessing Care

One of the most important components of health care access is acquiring, and maintaining, health insurance coverage. Children with insurance coverage are more likely to access preventive care services and have minor illnesses treated by a health professional before they develop into conditions that are more complex, expensive to treat, likely to result in emergency room visits, and traumatic for the affected child.[11]

In the U.S., citizen children whose parents were born in the U.S. are uninsured at a rate of 7 percent. By comparison, uninsured rates are twice as high for citizen children with foreign-born parents due to lower participation in both public and private coverage: 12 percent for those with naturalized parents, and 16 percent for those with non-citizen parents. Among non-citizen children with non-citizen parents, the uninsured rate skyrockets even higher, to 35 percent. Thus, immigrant children's insurance coverage is highly dependent not just on their own immigration status, but on that of their parents.[12]

Ensuring that children have comprehensive and continuous health insurance coverage is good not only for a child's health and quality of life in the short-term, but also a smart investment for the long-term. On average, child health coverage is exponentially less expensive than adult coverage. Studies have demonstrated that the health care costs of children are about one-tenth the health care costs of adults.[13,14] *Targeted health interventions, such as providing comprehensive asthma care to children, have the potential to reduce public health care costs in short and long term, i.e. through reduced emergency room use.*[15]

In addition, providing coverage for children today means potentially spending less for adult health care down the road. Children who receive regular check-ups and learn to engage in a healthy lifestyle have an improved chance of becoming healthy adults with less expensive medical needs than would be the case otherwise For example, adolescents with diabetes can learn how to successfully manage the disease with insulin, appropriate diet, and regular health screenings to avoid later complications like vision impairment and limb amputations.

While having health insurance is a critical step toward promoting a child's access to health care, insurance on its own does not guarantee that children get the services they need in order to be healthy. This disconnect between insurance coverage and service utilization is particularly pronounced for immigrant children, who face barriers to care regardless of insurance status. Like

insurance coverage, children's access to and utilization of care is significantly affected by parental citizenship status. Children whose parents are non-citizens are less likely than those with citizen parents to have visited a doctor, dentist, or mental health professional in the past year, with foreign-born, non-citizen children at particularly high risk compared to citizen children.[16]

In addition, disparities by immigration status are seen in a child having a "usual source of care," which can be defined as a health care provider or health care site where parents can bring their child when sick and ask questions about their child's health. Among children of foreign-born, non-citizen parents, 25 percent of children who were also foreign-born and 18 percent for children who were U.S.-born were reported to lack a usual source of care. Among children of legal immigrants, 12 percent of children who were naturalized U.S. citizens and 6 percent of U.S.-born children lacked a usual source of care.[17] *The care accessed by immigrants is also likely to be of lower quality than that accessed by native families, a phenomenon that is often attributed to the challenges immigrant parents have in building long-term relationships with providers.*[18],[19]

Despite the smaller percentage of non-citizen children who use emergency rooms in a given year compared to citizen children (12 percent and 22 percent, respectively), the costs for emergency room care are much higher per capita for non-citizen children. This suggests that there are substantial costs, both physical and financial, due to delayed medical care and poor access to primary care, since non-citizen children are often extremely sick by the time arrive at hospital emergency rooms.[20]

Lack of insurance coverage and access to timely, quality care are both major reasons why immigrant children are more likely than non-immigrant peers to be in poor health.[21] *Children of non-citizen parents are at particularly high risk, regardless of whether the child is a citizen.*[22] *A chronic condition like asthma exemplifies these disparities in health outcomes. A recent study of Hispanic children in New York City found that "asthmatic children from Spanish-speaking families were less likely to have an asthma diagnosis than children from English-speaking families but were twice as likely to be hospitalized for asthma (9.4 percent to 4.4 percent). A California study found a similar result, with asthmatic children of immigrants more likely to report fair or poor health status compared to asthmatic children in non-immigrant families.*[23] *These disparities are of serious concern not just in the short-term, but the long-term as well, jeopardizing children's development, ability to succeed in school, and future stability and productivity.*

Existing Barriers to Health Care

For immigrant children, the road to quality health care is often difficult to navigate. Being uninsured is one of the most significant barriers immigrant children can face in accessing care. However, there are many non-insurance barriers to care that also exist. Socioeconomic and legal status has a major impact on whether immigrants can acquire jobs with health care benefits, access insurance in the private market, or gain eligibility for public health insurance programs. In addition, limited English proficiency, complex and confusing policies, and fear of deportation can all imperil connections to coverage and care for immigrant parents and their children.[24]

Socioeconomic Status

While a range of factors put health insurance coverage and quality health care out of reach for immigrant children and families, arguably none is more fundamental, widespread, and pernicious than poverty. Children of immigrants are significantly more likely to grow up in poor households that struggle to meet basic needs, such as food and housing.[25] *In 2010, non-citizens living in the United States had a median annual household income of $25,000, compared to $48,000 for citizen households.*[26] *Consequently, 56 percent of young children of immigrants are low-income, compared to 40 percent of young children of U.S.-born parents. As a percentage of total child poverty, children from immigrant households represent 25 percent of the low-income children in the United States.*[27]

While the majority of adult immigrants are employed, they typically work in lower wage jobs that are less likely to offer health insurance and for which insurance purchased in the individual market may be unaffordable.[28] *In addition, immigrant families may face other health-related financial impediments that obstruct access including out-of-pocket costs for appointments and prescriptions and lack of paid sick leave or transportation options to bring children to appointments.*[29]

Lack of Access to Public Insurance Programs

In order to access public benefits, immigrants must navigate a complex patchwork of federal eligibility rules and state policies. Unauthorized immigrants are at a unique disadvantage, as they are almost completely barred from public benefits including health care. Some limited exceptions apply. Medicaid payments may be made for emergency services (including labor and delivery) for people who would otherwise be eligible for Medicaid if they were citizens. Some states fund their own health programs to cover selected groups of low-income immigrants—including unauthorized immigrants—who would otherwise be ineligible for Medicaid and CHIP, and also offer prenatal care

to women regardless of immigration status by extending CHIP coverage to the unborn child. Four states (MA, IL, NY, WA) and Washington, DC provide coverage to children, regardless of immigration status.[30]

Immigrant Category	ACA Health Reform Subsidies (tax credits and cost-sharing reductions)	Medicaid	CHIP
Lawful Permanent Resident (age 18 and over)	Eligible	Not Eligible until after 5-year waiting period	Not Eligible until after 5-year waiting period
Lawful Permanent Resident (under age 18)	Eligible	State Option to provide without a 5-year waiting period	State Option to provide without a 5-year waiting period
Lawful Permanent Resident (pregnant women)	Eligible	State Option to provide without a 5-year waiting period	State Option to provide without a 5-year waiting period
Refugees, Asylees, Victims of Trafficking	Eligible	Eligible	Eligible
Lawfully Present Individuals	Eligible	State Option for children <21 and pregnant women	State Option for children under 21 and pregnant women
Unauthorized Immigrants (including children and pregnant women)	Not Eligible (and barred from purchasing coverage on their own in the Exchange)	Eligible for Emergency Medicaid Only	Not Eligible

Source: National Immigration Law Center

Historically, authorized immigrants were eligible for publicly funded services based on the same eligibility criteria that applied to citizens.[31] *Legal immigrants' access to such services changed in 1996, with passage of the Personal Responsibility and Work Opportunity and Reconciliation Act (PRWORA). This federal law cut off access to a range of health and social service programs for an immigrant's first five years of residence including Medicaid, the State Children's Health Insurance Program (CHIP), cash welfare assistance, and food stamps.*[32]

As part of the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA), states were given the option to use federal funding to extend coverage to authorized immigrant children and pregnant women during their first five years in the U.S. (See page 11 for state-by-state comparison of laws.) As of January 2013, 25 states have chosen to use this option to provide coverage for children in Medicaid and CHIP and 20 have done so for pregnant women.[33] *While this is a promising sign for a select group of legal immigrants in those states, the five-year waiting period still applies to pregnant women and children in more than half of states. Despite state-funded extensions in coverage and extensions covered by CHIPRA, PRWORA has ultimately led to a*

substantial reduction in the level of public assistance sought and accessed by authorized immigrants.[34]

Absent public or private health insurance, unauthorized immigrants may seek care at hospital emergency rooms. Under the federal Emergency Medical Treatment and Active Labor Act (EMTALA), any patient found to be in need of emergency treatment who arrives at an emergency room of a Medicare-participating hospital must be treated until stable. Some states also offer Medicaid coverage for emergency care ("Emergency Medicaid"), though definitions of emergency care and an approved list of services covered vary by state. While EMTALA and Emergency Medicaid mandate emergency care regardless of ability to pay or immigration status, this form of health care delivery does not address ongoing medical needs, such as care for chronic conditions, performance of well-child check-ups, developmental/behavior screening, or anticipatory guidance and health education.[35]

While federal funds may not be used to provide non-emergent health care to unauthorized immigrants and their children, there are some states and local governments that have used their own funds to provide medical services to these populations. While these state-level services fill crucial gaps, there is no significant national program that covers unauthorized immigrant children. Consequently, safety net institutions—including public and not for profit hospitals, federally qualified community health centers, and migrant health centers—largely assume the care of uninsured immigrants. After the ACA is fully implemented, the unauthorized immigrants who remain uninsured will be particularly reliant on these safety net institutions for care.

Confusion and Fear

PRWORA is a primary example of the way in which restrictive policies, opaque bureaucracy, and valid fears discourage immigrants from accessing health and social services. In what is referred to as the "chilling effect," research has shown that many eligible immigrant families hesitate to enroll in public benefit programs due to confusion about eligibility requirements and fear of adverse immigration consequences. Whether real or perceived, these risks and barriers have a negative impact on care, coverage, and outcomes exacerbating challenges the population already faces in accessing health care.[36]

State	Lawfully-Residing Child Immigrants Covered without 5-Year Wait	Lawfully-Residing Pregnant Women Covered without 5-Year Wait
Total	**25**	**20**
Alabama		
Alaska		
Arizona		
Arkansas		
California	✓	✓
Colorado		✓
Connecticut	✓	✓
Delaware	✓	✓
District of Columbia	✓	✓
Florida		
Georgia		
Hawaii	✓	✓
Idaho		
Illinois	✓	
Indiana		
Iowa	✓	
Kansas		
Kentucky		
Louisiana		
Maine	✓	✓
Maryland	✓	✓
Massachusetts	✓	✓
Michigan		
Minnesota	✓	✓
Mississippi		
Missouri		
Montana	✓	
Nebraska	✓	✓
Nevada		
New Hampshire		
New Jersey	✓	✓
New Mexico	✓	✓
New York	✓	✓
North Carolina	✓	✓
North Dakota		
Ohio		
Oklahoma		
Oregon	✓	
Pennsylvania	✓	✓
Rhode Island	✓	
South Carolina		
South Dakota		
Tennessee		
Texas	✓	
Utah		
Vermont	✓	✓
Virginia	✓	✓
Washington	✓	✓
West Virginia		
Wisconsin	✓	✓
Wyoming		

Oftentimes, eligible immigrants assume they should not seek services or are provided with erroneous guidance by eligibility workers or advocates who themselves are confused by the maze of regulations. For example, non-citizen parents who are excluded from public health programs or employer-sponsored private health care may perceive that the documentation restrictions also apply to their qualified citizen children and ultimately not enroll their children. Even if they do decide to enroll their children they may find the actual enrollment process too complex and inaccessible to individuals with limited English proficiency and literacy.[37] Among mixed-status families, the process of sharing personal information through enrollment and other processes may heighten fears of deportation and serve as a deterrent to seeking timely health care.

Finally, language and cultural barriers may further limit parents' knowledge of health care benefits, needs, and services, hinder their ability to communicate with providers, and limit their capacity to advocate for their children.[38] Moreover, studies have shown that foreign-born individuals are more likely to experience discrimination in health care than their U.S.-born counterparts, are more likely to report difficulty understanding their providers, and report lower satisfaction with care. [39],[40] A lack of clear information and adequate support compounds existing financial and legal fears. In turn, immigrants and their families are less likely to get the coverage and care for which there is clear eligibility and significant need.

ACA Largely Excludes Coverage of Immigrant Children

The ACA makes major strides in increasing access to health insurance for low-income populations. It requires states to expand Medicaid to people under age 65 with incomes up to 133 percent of the federal poverty level. It will also allow individuals to "shop" for health insurance through new health insurance exchanges, while offering tax credits to help subsidize the costs of coverage in these insurance marketplaces.

But for many immigrant children and families, these ACA benefits will remain out of reach. The Government Accountability Office estimates that approximately 880,000 non-citizen children will be left uninsured even after full implementation of the ACA in 2014.[41] This is the largest single group of kids left out of health reform. The barriers to gaining health insurance coverage that will continue to exist for immigrant children include:

- *Unauthorized immigrants are barred from participating in expansions in public health care programs for the uninsured. Unauthorized immigrants remain ineligible for Medicaid and CHIP in many states and are excluded from the Medicaid expansion under ACA. They are barred from purchasing insurance coverage through an exchange, even at full cost, and are ineligible for premium tax credits or cost-sharing subsidies.[42] Citizen or lawfully present children of unauthorized parents may be able to purchase "child-only" coverage through the exchanges, and be eligible for premium tax credits and reduced cost-sharing for their child's coverage. However, it is likely that unauthorized parents will be wary to enroll their children in fear of exposing their own immigration status.*

- *Unauthorized children accepted into the DACA program will be ineligible for public health program coverage. While this new designation permits eligible young people to remain in the U.S. without the threat of deportation, DACA specifically excludes beneficiaries from being eligible for Medicaid and CHIP. They are also excluded from participation in the exchanges and premium tax credits. This is a major departure from earlier, pre-DACA forms of deferred action, whereby designees were eligible for the same public programs as their citizen counterparts.[43]*

- *Lawfully residing immigrants will continue to be subject to the five-year waiting period for Medicaid and CHIP coverage in most states. States will retain the option to provide coverage under CHIPRA to lawfully residing children and pregnant women regardless of their length of time in the country.[44] However, lawfully residing immigrants will be able to purchase coverage in an exchange, so long as their income is below 400% of poverty and they lack access to affordable employer-based coverage. These individuals can be eligible for premium tax credits and cost-sharing subsidies. This includes those with incomes below 133 percent of poverty who are ineligible for Medicaid as a result of the five-year waiting period.[45]*

- *"Mixed-status" families, where children are citizens and parents are not, can result in a range of ACA related eligibility scenarios. For these families some members will be eligible for coverage through Medicaid or exchanges and some not. Confusion around these scenarios, complicated verification requirements, and fears about adverse immigration consequences for the non-citizen members of the family all decrease the likelihood that immigrant children will receive the health care coverage for which they are legally eligible.[46]*

Opportunities to Extend Coverage in National Immigration Reform

As Congress moves forward with efforts to reform federal immigration laws, it is critical that attention be paid to the unique needs of children. The American Academy of Pediatrics states that "Every child within the geographic boundaries of the United States, regardless of that child's 'status,' should have full access to all social, educational, and health services that exist at the local, state, and federal levels for the care and benefit of children. Allowing any group of children to be uneducated or unhealthy will have adverse consequences for all of us."[47] The debate in Congress about how to change America's current immigration system provides an opportunity to ensure that the nation is stronger, safer, and more stable in part by ensuring all children who live here have the chance to reach their full potential. Access to health care services is a vitally important piece of this effort.

For all the same reasons that U.S.-born children need and deserve access to health care, immigrant children do as well. Because of their age and developmental stage, children need ongoing access to preventive health services including surveillance for emerging health and developmental problems. Infants and young children require an extensive series of well-baby and well-child visits for immunizations, screenings, and parental guidance. Chronic conditions must be identified and effective treatment provided as early as possible to prevent later, more severe health consequences. Without timely access to primary care, children with chronic conditions like asthma rely on hospital emergency rooms where care is most costly.

Increasing access to timely health care for immigrant children makes sound financial sense, as it can help to reduce health care expenditures in the short and long term by increasing preventive care and reducing the need for costly, complex emergency treatment. While immigrants visit the emergency room less frequently than non-immigrants, they are often sicker when seeking care and thus emergency room expenditures are disproportionately high. This is largely the case because of lack of health insurance or other barriers. Consistent access to primary and preventive care can help prevent certain conditions from worsening, diseases from spreading, and costs from rising.[48] In short, ensuring that immigrant children have comprehensive and continuous health insurance coverage and access to care is good not only for their wellbeing in the short-term, but also a smart investment for the long-term. While immigration reform may at times be complex and controversial, allowing children the chance to learn, play, and grow into healthy and productive adults is not. The next generation of children—regardless of where they or their parents may happen to have been born—must have the opportunity to be healthy and successful. By ensuring their wellbeing we can help guarantee the well-being of our nation as a whole.

Policy Recommendations

As federal legislation to help the 1 million undocumented children of this country obtain citizenship moves closer to reality, action is needed now more than ever to ensure immigrant children have the opportunity for a healthy start in life. It is both irresponsible and unjust to exclude children residing in this country from accessing health care based on factors outside of their control. For all the same reasons that U.S.-born children need and deserve access to health care, immigrant children do as well. In addition, not only is investing in health care for children a smart investment for the short – term but also for the long-term. We know that covering kids is far less costly than adult coverage and healthy children have a better chance of becoming healthy adults. It is critical that lawmakers act now to ensure this group of children is provided access to health care. There are several actions that the President, Congress, state governments and the health care community should take going forward:

- ***Allow DACA-designated children access to public health programs**. In the unprecedented act of denying public benefits to deferred action designees, the Administration has erected a barrier to health care access for lawfully-residing immigrants. The President should immediately amend the rules of the DACA program to allow enrollment in the same public health care programs that other deferred action designees currently access.*

- ***Provide a direct, clear, and expedited path to citizenship for unauthorized children.** When crafting and considering federal immigration reform legislation, Congress should ensure that children's needs are specifically prioritized and addressed. Providing an expedited and immediate pathway to citizenship for children is one way to ensure that all kids are provided the opportunity for a healthy start in life. If citizenship status for children is not immediate then legislation should include access to health care, education, nutrition and other public and safety-net programs for children during any provisional status. There are no "do-overs" for childhood. A potential pathway to citizenship that takes 10 years or more—with a potential 5-year waiting period for enrollment in many programs on top of that—could mean an entire childhood devoid of the appropriate supports that ensure a child's success in the future.*

- ***Lift the Medicaid and CHIP 5-year ban for authorized children**. Given the relatively high rates of uninsurance among authorized immigrant children, policy changes are needed to expand public health safety net access to health insurance for these kids. All states should adopt the federally-funded option allowed under CHIPRA to expand Medicaid and CHIP programs to authorized immigrant children and pregnant women without a 5-year waiting period. Congress should also*

explore ways to require the remaining states that currently still have the 5-year ban to lift this waiting period for children and pregnant women.

- ***Allow access to ACA for all children.*** *Currently unauthorized children will not have access to the new exchanges, even if their parents wish to purchase child-only coverage for them at full-cost. These families also do not have access to premium and cost-sharing supports available to help lower income families purchase health care coverage for their kids. All children, regardless of status should have access to the expansions of care offered by ACA, including the new exchanges.*

- ***Establish uniform public health program eligibility rules for all children.*** *Any federal or state legislation that seeks to extend coverage to immigrant children through Medicaid, CHIP or ACA should do so under the same requirements that apply to citizens. Creating new programs or different eligibility rules for existing programs only adds to parents' confusion, which in turn reduces the likelihood that they will enroll their children in the program.*

- ***Remove linguistic barriers to care.*** *A provider's ability to communicate information such as asthma prevention protocols or prescription medication regimens is critical to ensuring quality health outcomes. As language barriers will exacerbate health disparities for immigrant children and their parents, stricter enforcement should be required of Title VI of the Civil Rights Act to provide assistance to individuals with limited English proficiency. In particular, the health care sector should invest in expanded use of interpreter services and bilingual staff, especially in communities with large number of immigrant families.*[49]

Immigration reform legislation provides an ideal opportunity at the federal level to help finish the work of the ACA in extending health coverage and access to all children of this country. States can take advantage of existing options through current law to help bring immigrant children into the ranks of the insured. In addition, the private health sector can take certain actions in reducing non-insurance barriers to care in the provider setting. It is critical that action is taken swiftly in order to ensure that all children living in this country have access to quality health care and have the opportunity to reach their full potential.

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