



**Rutgers** Center for  
State Health Policy

*The Institute for Health, Health Care Policy and Aging Research*

# **State Practices in Health Coverage for Immigrants: A Report for New Jersey**

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## Acknowledgements

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## Foreword

This report was funded by the New Jersey Consumer Voices for Coverage project, under a grant from the Robert Wood Johnson Foundation. It provides background information for those who are interested in the subject of health coverage for immigrants. The New Jersey Consumer Voices project supports the work of a coalition of organizations interested in advancing public education on state and federal policies to expand health care coverage (see: <http://www.voicesforcoverage.org/states?id=0030> for more information). As this report demonstrates, health insurance coverage for immigrants raises unique and complex challenges.

The Center for State Health Policy is a unit of the Institute for Health, Health Care Policy and Aging Research at Rutgers University (see: [www.cshp.rutgers.edu](http://www.cshp.rutgers.edu) for more information). The mission of the Center is to inform, support, and stimulate sound and creative state health policy in New Jersey and around the nation. In pursuit of our mission, the Center conducts research, serves as a neutral convener, and provides consultation, but we do not take public policy advocacy positions. Our aim in preparing this report is to provide impartial information and rigorous analysis to Consumer Voices and the wider community of health policy stakeholders to use in policy deliberations in New Jersey.

The Center, established in 1999, has conducted extensive research on health insurance coverage policies. An extensive array of publications is available on the Center's web site providing a detailed profile of the uninsured and evaluating coverage policies. Beginning later this year, we will add to our publication portfolio with a new series of reports about coverage, access to care, and related topics based on the 2009 New Jersey Family Health Survey. Additional analysis of coverage for immigrants will be among the topics that Center analysts will address using this new and rich data source.

Joel C. Cantor, ScD  
Professor and Director  
May 26, 2009





# State Practices in Health Coverage for Immigrants: A Report for New Jersey

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Marsha Rosenthal, M.P.A., Ph.D.

## Executive Summary

New Jersey Consumer Voices for Coverage, an initiative undertaken by a coalition of New Jersey groups, focuses on identifying policies that can expand health coverage to New Jersey's 1.3 million uninsured residents. The coalition's initial focus is extending coverage to all of New Jersey's children, as well as low and moderate-income adults, and non-citizens.

This report was prepared by the Rutgers Center for State Health Policy to provide the background for a greater understanding of the current environment for health coverage of immigrants in New Jersey. The aims of this report are to:

- Identify policies for providing coverage to immigrants;
- Describe policies in New Jersey to allow for comparison to those in other states;
- Provide information on practices in other high-immigrant states.

The Rutgers Center for State Health Policy gathered data through the following methods:

- In depth review of the available literature (citations shown in References). We also compiled an extensive annotated bibliography (available upon request).
- Key informant interviews of researchers, policy analysts, advocates, and state officials. We chose four states (Illinois, New York, California and Massachusetts) that are considered leaders in covering immigrants regardless of their status. Three of these- Illinois, New York and California- along with New Jersey, are in the top seven states with the largest immigrant populations (the others are Texas, Florida and Arizona). In October 2008, we also participated in a roundtable discussion with New Jersey advocates who work with immigrants.

Based on these data, we report on the barriers faced by immigrants, health coverage under government programs, health coverage in the New Jersey context, and alternate state models of health coverage, to provide a snapshot of health coverage for immigrants as of spring 2009.

## *Findings*

Immigration and health care are each complex topics, nationally and in New Jersey. This report focuses on one piece of the puzzle: health coverage for immigrants, who make up more than a

fifth of the New Jersey population. Many immigrants, both those with legal and undocumented status, face barriers to obtaining or using health coverage.<sup>1</sup>

This is a particularly dynamic time for U.S. social and health policies. Passage of federal legislation re-authorizing the State Children's Health Insurance Program or SCHIP (now called the Children's Health Insurance Program or CHIP)<sup>2</sup> in January 2009 was one of the first policy initiatives of the current Congress and of the Obama administration. This presages changes at the state level, as this legislation will be implemented by the states. Further efforts for national health reform are expected in the next year, and these reforms will also likely affect the availability of coverage for immigrants. The data in this report reflect the most current information available as of spring 2009.

### **Barriers faced by immigrants in obtaining and using health coverage**

Immigrants face barriers at the system, community, and person levels. Many of the barriers to health coverage also pose barriers to accessing health services. The most frequently cited barriers are: legal and regulatory restrictions and employer limitations on health coverage available to immigrants; language barriers; and fear of exposure to legal authorities.

### **Health coverage under government programs**

Low income immigrant children and parents who are citizens or hold legal status are eligible for Medicaid or CHIP. Since 1996, immigrants have not been eligible for federal funding under these programs during their first 5 years of U.S. residency. However, several states have continued to provide them with this coverage, using state- only dollars. On February 4, 2009, President Obama signed into law a major revision of the program, P.L. 111-3, the "Children's Health Insurance Program Reauthorization Act of 2009". Amending Title 21 of the Social Security Act, the new law (known as CHIPRA) extends and expands the program (changing the name of the program from SCHIP to CHIP). The focus of the changes is on children and pregnant women. As of April 2009, these changes to federal law now allow states to provide Medicaid and CHIP coverage to legal immigrants with federal funding participation. Five states (and the District of Columbia) currently also provide coverage for children (but not adults) with undocumented status, using state dollars. The "safety net" providers, particularly Federally Qualified Health Centers (FQHCs), provide direct access to health services for immigrants, where available.

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<sup>1</sup> In focusing on coverage issues, including public (government) and private (mostly employer based) health insurance, we are only indirectly addressing availability or access to health care services for immigrants. Obtaining and using coverage is separate from access to health care services, although access to services is highly dependent on coverage.

<sup>2</sup> The acronym for the State Children's Health Insurance Program was SCHIP until recent federal legislation renewing the program changed the name to Children's Health Insurance Program (CHIP). In this report, we refer to the program prior to spring 2009 as SCHIP, and after that date as CHIP.

## **Health coverage – the New Jersey context**

New Jersey has been providing SCHIP coverage using state only dollars for low income immigrant children and parents who hold legal status within the 5 year residency window. New Jersey also has 19 FQHCs that provide safety net services.

In July 2008, the New Jersey Health Care Reform Act of 2008 mandated that all children in the state have public or private health coverage. New Jersey's SCHIP, NJ FamilyCare, provides coverage for all eligible children, including immigrant children who are citizens or have legal status, up to 350% of the federal poverty level. New Jersey also has an expansion program, NJ FamilyCare Advantage, as a buy in option for all children with household incomes over 350% of the poverty level. The new federal law is expected to provide important financial assistance in carrying out the mandate to cover all children, and may allow continued coverage of some parents. As a result of interdepartmental efforts by the state under the 2008 law, new outreach efforts and a more streamlined enrollment process are being developed, which could address some of the existing barriers to enrollment.

## **Health coverage – alternative state models**

The states with the largest immigrant populations are California, New York, Texas, Florida, New Jersey, Illinois and Arizona. Three of these states – California, New York and Illinois - are in the forefront of coverage for immigrants, along with Massachusetts, which has reformed its entire approach to health coverage. With the exception of Illinois, which has a unified program, the states cover low income immigrants through a patchwork of programs. In order to get an idea of the type of coverage available in these states, we conducted semi-structured interviews with experts in California, Illinois, Massachusetts and New York. We also examined materials about Pennsylvania's programs, because of the proximity of the state to New Jersey. We briefly describe the program, we list the coverage available for immigrants of legal and undocumented status, and we describe successful outreach and enrollment methods.

## ***Conclusion***

New Jersey faces serious challenges in covering health care for its immigrant population. The population is diverse, including many immigrants who are highly educated and skilled, who work in positions providing private health insurance. Many other immigrants, both legal and undocumented, are employed in jobs that provide little or no private coverage. The public coverage available reflects a patchwork of programs, eligibility and income requirements. This suggests the need for a public policy solution to address the immigrant population's needs for health coverage.

A number of high immigration states, including New Jersey, are attempting to provide greater outreach and cover more of their immigrant residents. Each state provides a slightly different policy alternative, but the most comprehensive coverage in these states is available to children of immigrants, particularly citizens and legal immigrants. Recently passed federal legislation is

expected to increase the coverage available through these programs. New Jersey is among the group of states with high immigrant populations that provide comparatively more public coverage and safety net programs. However, compared to other states with large immigrant populations and similar state economic circumstances, New Jersey has not been a leader. The passage of last year's New Jersey health legislation (PL 2008, C.38 / S1557 3R), and the efforts of the resulting Outreach, Enrollment and Retention Work Group, could offer the state an opportunity to improve coverage for immigrants.

The coverage of immigrant adults, particularly undocumented adults and those without children remains an unmet need. The overall quandary of immigration is a national policy issue, requiring a political resolution at the federal level. In the more immediate future, New Jersey faces continuing questions of affordability of its expanded coverage for low-income children and their parents, which include some immigrants. Maintaining the course in the face of severe state budget constraints makes implementation a challenge at the state level.

# State Practices in Health Coverage for Immigrants: A Report for New Jersey

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Marsha Rosenthal, M.P.A., Ph.D.

## Introduction: Citizenship Status and Health Insurance Status

To put the issue of health coverage for immigrants in context, this section provides an overview of data on citizenship status and health insurance status for the U.S., New Jersey, and four other states for comparison (see Tables 1-4).<sup>3</sup> There are about 18.2 million non-citizen adults and 2.6 million non-citizen children in the U.S.<sup>4</sup> In New Jersey, there are 845,000 non-citizen adults and 144,000 non-citizen children.<sup>5</sup> The proportion of foreign-born children who are non-citizens is higher in New Jersey (87%) than in the nation as a whole (81%). The reverse is true of foreign-born adults who are non-citizens (62% nationally; 59% in New Jersey).

**Table 1. Foreign-born Children – citizenship status**

	Percentage who are citizens	Percentage who are not citizens
US	19	81
NJ	13	87
NY	28	72
CA	16	84
IL	24	76
MA	30	70
PA	33	67

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<sup>3</sup> The literature and other studies identify immigrants in several ways that are not mutually exclusive: foreign-born, non-citizens, documented/undocumented; legal/illegal; authorized/unauthorized. For purposes of this report, we will refer to immigrants as either being citizens, or having legal or undocumented status, since these terms are the ones commonly used. These categories affect eligibility for health coverage under government sponsored programs. In addition, since children are generally covered by programs differently from adults, we will identify the differences in coverage practices for children and adults.

<sup>4</sup> Among these non-citizens, an estimated 11.8 million in the U.S. have undocumented status, including 1.7 million children under age 18. About 470,000 or almost one-third of all New Jersey's immigrants were undocumented (28,67).

<sup>5</sup> The U.S. Census Bureau's Current Population Survey provides comparison data for immigrants and health coverage. The CPS uses the term "foreign born" to refer to anyone who is not a U.S. citizen at birth. "Non-citizens" refers to all foreign-born who do not have naturalized citizen status, and others, including immigrants with undocumented status.

**Table 2. Foreign-born Adults – citizenship status**

	Percentage who are citizens	Percentage who are not citizens
US	38	62
NJ	41	59
NY	48	52
CA	40	60
IL	36	64
MA	45	55
PA	47	53

Looking at health coverage for this population, the percentage of foreign-born children (see Table 3) who are uninsured is higher in New Jersey (37%) than in the U.S. (33%). The proportions are reversed for foreign-born adults (37% in U.S.; 33% in New Jersey). In terms of public versus private insurance, foreign-born children in New Jersey are more likely to have coverage under a public program (35%) than private health insurance (28%). This is the reverse of the proportions for foreign-born children nationally (23% public coverage vs. 44% private coverage). Foreign-born adults (see Table 4) in New Jersey are much more likely to have private coverage (62%) than public coverage (5%), and this is also a greater proportion than in the nation (55% private coverage vs. 8% public coverage) (67).

**Table 3. Foreign-born Children- insurance status**

	Percentage Uninsured	Percentage Publicly Insured	Percentage Privately Insured
US	33	23	44
NJ	37	35	28
NY	14	41	45
CA	27	38	36
IL	25	24	51
MA	>1	40	60
PA	24	26	50

**Table 4. Foreign-born Adults- insurance status**

	<b>Percentage Uninsured</b>	<b>Percentage Publicly Insured</b>	<b>Percentage Privately Insured</b>
US	37	8	55
NJ	33	5	62
NY	28	19	53
CA	37	11	52
IL	32	4	64
MA	13	19	68
PA	22	8	70

Source: Tables 1-4, Current Population Survey, March supplement 2008

In New Jersey, approximately one of every two foreign- born, non-citizen adults is uninsured. Among foreign-born children in New Jersey, approximately 1 in 10 who are citizens, and 1 in two who are non-citizens, are uninsured. Hispanic children are the most likely to lack coverage, with an uninsured rate four times that for non-Hispanic white children (14). Although a large percentage of New Jersey immigrants are covered by private health insurance (62% for adults; 28% for children), many of these privately-insured immigrants are citizens.

## **Methods**

For this report, we examined the literature in several key areas: legislative policy on coverage (state and federal); background demographics on immigrant populations and data on coverage; and access to services. We examined peer-reviewed journal articles, newspaper articles, and reports from policy and research centers (see References).

We interviewed twelve key informants, including policy analysts and other researchers, advocates, and state officials (see Appendix A for list of key informants). In addition to New Jersey, we chose four states that are considered leaders in covering immigrants regardless of status: Illinois, New York, California and Massachusetts. The interview protocol was semi-structured, to address the following topics: 1) unique aspects of each state’s program in covering immigrants; 2) coverage for immigrants with undocumented status; 3) elements of the state’s program that are working well or not working well; 4) sustainability of the program; and 5) political issues confronting the state’s program.

We also participated in a roundtable discussion with advocates for New Jersey’s immigrants in October 2008 (see Appendix B for additional information)

## Findings

### ***Barriers faced by immigrants in obtaining and using health coverage***

In October 2008, we participated in a roundtable discussion with eight advocates for immigrants who are also part of the leadership of NJ Consumer Voices for Coverage. Our purpose was to learn from the members' experiences and observations. We were particularly interested in identifying the barriers to health coverage for immigrants in New Jersey.

The participants were very knowledgeable about this complex subject. Three main points emerged:

- Access to a continuum of care – particularly access to specialist care - is a critical problem for immigrants in New Jersey. Immediate care and primary care is provided by the Federally Qualified Health Centers (FQHCs) and hospital emergency rooms in New Jersey.
- Barriers to coverage that were cited include language barriers, fear of deportation of family members, and domestic violence.
- The payer mix at FQHCs is switching to more uncompensated care (because more of the patients are not eligible or able to obtain Medicaid or SCHIP), which is causing funding problems.

The report of the Governor's Blue Ribbon Advisory Panel on Immigrant Policy (49) cites very similar barriers, along with lack of insurance coverage as barriers to accessing care and medications, especially for immigrant children. In a recent presentation of his research, Princeton professor Alejandro Portes also cited three similar barriers: 1) lack of information about free clinics and services other than the emergency room, 2) cultural and linguistic barriers, 3) fear of detention or deportation, triggered when confronted with bureaucratic rules and billing. ("Life on the Edge: Immigrants Confront the American Health System", Rutgers University, April 14, 2009).

Based on the roundtable discussion and findings in the literature, immigrants confront system level, community level, and personal barriers when they attempt to obtain health coverage and accessing health care services. Some examples of these barriers are listed below.

*System level barriers* include: lack of health insurance provided by employers in the sectors where immigrants work; federal and state laws and regulations which are restrictive in provision of health coverage to immigrants.

*Community level barriers* include: cultural beliefs about use of health services; lack of transportation alternatives; language barriers; lack of information about services in Spanish and other languages; limits on availability of health services.



*Person level barriers* include: individual attitudes about health and illness (e.g.: importance of self-reliance), lack of awareness of the need for health insurance in the U.S. (when people come from countries with socialized medical care), fear of consequences when confronting officials in the health system (e.g.: concerns about being reported to immigration authorities).

These barriers could be addressed with a multi-level strategy. Recent federal and state policy changes include reducing restrictions on coverage for legal immigrants, expanding the income eligibility for CHIP, and increasing the federal allocation for CHIP and safety net services. One barrier that has not yet been directly addressed in these measures is affordability. However, according to some policy experts, these system level barriers are not the biggest problem for covering children. The children of immigrants are mostly citizens, and therefore eligible for Medicaid and/or CHIP. Community level and person level barriers pose continuing problems, even when children are eligible for coverage. These barriers require a set of outreach and enrollment strategies, such as streamlining enrollment forms and processes, making forms and information available in multiple languages, and engaging trusted community organizations in the effort to encourage low-income immigrant parents to enroll their children in public insurance.

### ***Health coverage under government-sponsored programs***

Since 1996, federal law has prohibited undocumented immigrants and recent legal immigrants from receiving coverage under federally funded programs. Some states, including New Jersey, have been using state-only funds to address this gap in coverage for low income residents (Table 5). In general, however, non-citizens have more restricted access and less use of health care services, on such measures as having a usual source of care, contact with a professional, primary care and even emergency room use (20). (Appendix C provides a brief overview of program eligibility and limitations from 1996-2009).

Recently, these limitations on government coverage have been eased under P.L. 111-3, the “Children’s Health Insurance Program Reauthorization Act of 2009” (CHIPRA). Expanded safety net services are also expected to address some of the difficulties in health care access. An additional 6.5 million children can now be enrolled in Medicaid or CHIP nationally (including native and foreign-born children). States now have the option to provide coverage, with federal funding participation, to children and pregnant women of documented status in their first five years in this country. New rules would be applied to coverage for parents and childless adults under CHIP. New Jersey (and New York) will be able to offer their CHIP programs to families at incomes up to 350% of the federal poverty level.

The changes improve coverage for low income children who are citizens and legal immigrants. The main methods in CHIPRA are additional financing and incentives for states to enroll low income children, as well as incentives to for states to do outreach and simplify enrollment, and an enhanced match for translation and interpretation services (9). It remains to be seen which states will take advantage of these options, and how they will implement the changes. The

legislation offers fiscal assistance to states like New Jersey, by restoring federal matching funds for SCHIP expenditures that are currently covered with state-only dollars.

The safety net is also being reinforced under the federal stimulus bill. On March 2, the federal government announced that \$155 million would be used to establish 126 new FQHCs. On March 27, the federal Department of Health and Human Services announced that it would provide \$338 million to 1128 FQHCs to expand services over the next two years. In New Jersey, this included grants over \$6.8 million to 20 FQHCs, to provide care to approximately 57,000 new patients, of whom 39,000 are expected to be uninsured.

However, one of the remaining difficulties in providing public coverage to immigrants is the blended nature of many immigrant families. Coverage under public programs (e.g., Medicaid or CHIP) is offered only to citizens and legal immigrants. Because all children born in the U.S. are automatically citizens, it is not uncommon for a child who is a citizen to have one or both parents, or an older sibling, who is not a legal immigrant. Nationally, about 4 million children have at least one parent who is not a legal immigrant, while 73 percent of children of undocumented immigrants are American citizens (72). This leads to families with mixed status regarding their eligibility for publicly-sponsored health coverage, and creates barriers that will be further discussed in this report.

According to one key informant, the most serious coverage problem confronting immigrant families beyond eligibility for government programs is their lack of access to private health insurance. Based on his research, citizen children of low-income immigrants receive Medicaid and Children's Health Insurance Program (CHIP) coverage in the same proportions as low-income, non-immigrant children. However, they receive much less private coverage, because their parents do not get private coverage. Often this is a matter of the types of jobs the parents hold, which do not offer private coverage. Another reason for the lack of private coverage is explicit discrimination in the workplace. (Leighton Ku, personal communication, December 4, 2008).

**Table 5. Health Coverage Under Government Programs by Citizenship and Immigration Status**

CHILDREN			
Immigraton status	Medicaid	SCHIP/SCHIP +	State-only Funds
<b>Citizens</b>	All States	All States	
<b>Legal status</b>	All States after 5 year waiting period	All States after 5 year waiting period / States have option to include under CHIP (4/1/09)	CA, CT, DC, DE, MN, IL, ME, MD, MA, NE, NJ, NY, PA, VT, TX, VA, WA
<b>Undocumented status</b>			CA, DC, IL, MA, NY, WA
ADULTS			
Immigration status	Medicaid	SCHIP/SCHIP +	State-only Funds
<b>Citizens</b>	All States	All States	
<b>Legal status</b>	All States after 5 year waiting period	All States after 5 year waiting period	CA, CT, DE, ME, MD, MA, MN, NJ, NY, PA, IL <sup>6</sup>
<b>Undocumented status</b>		<b>Prenatal Care Only:</b> AR, CA,CO, IL, LA, MA, MI, MN, NE, PA, NY, RI, TX, WA, WI	CA <sup>7</sup> , DC

Source: Table 5 reflects data as of 1<sup>st</sup> quarter of 2009, prior to implementation of CHIPRA

### ***Health Coverage – The New Jersey Context***

As noted above, there are 845,000 foreign-born, non-citizen adults and 144,000 children in New Jersey.<sup>8</sup> This overview reflects published reports about New Jersey’s coverage for immigrants, and our discussion with state administrators for the NJ FamilyCare program (see Appendix A).

<sup>6</sup> IL only has coverage for documented immigrant adults (before the 5 year bar) for family planning.

<sup>7</sup> CA only has restricted coverage for undocumented immigrant adults, covering long term care, breast and cervical cancer screening and treatment.

<sup>8</sup> For purposes of this report, we have divided adults into the population aged 18-64, and those over age 65. This is because two-thirds of the foreign-born over 65 population in New Jersey are citizens and eligible for Medicare. We are reporting about the adult population ages 18-64.

The state provides health coverage programs for low-income citizens and legal immigrants, particularly through Medicaid and NJ FamilyCare, which are administered by the Division of Medical Assistance and Health Services within the New Jersey Department of Human Services. Undocumented immigrants are not covered, but receive services solely through the “safety net” providers of FQHCs and hospital charity care. In discussing the size of the problem, it is important to recognize that among the estimated 20% of the New Jersey population who are immigrants, only a small portion is undocumented. It is estimated that 470,000 New Jersey residents were undocumented immigrants in 2007, representing 5.4% of the state’s 8.7 million people. In 2000, the estimate was 350,000 undocumented immigrants, or 4.2% of the total 8.4 million population (28, 67).

In 2001, New Jersey was one of the first states to receive a waiver to expand the SCHIP program to cover parents. The waiver allowed New Jersey to use federally matched SCHIP dollars to cover parents and pregnant women with incomes up to 200% of the federal poverty level. As of May 2009, NJ FamilyCare was covering approximately 133,000 children and 136,000 adults.<sup>9</sup>

In July 2008, the New Jersey Legislature enacted new legislation establishing mandates for health care coverage of all eligible children (The New Jersey Health Care Reform Act of 2008, PL 2008, C.38 / S1557 3R). The legislation stipulates a "soft" mandate (meaning there is no penalty imposed if parents do not have insurance for their children) that all children have public or private health coverage. To assist New Jersey families in obtaining health insurance, the bill set forth market reforms and called for a working group of state agencies and stakeholders to focus on improved outreach and enrollment methods.

The eligibility for NJ FamilyCare includes children with a family income up to 350% of the federal poverty level (\$77,500 for a family of 4), and has included qualified immigrant children before the end of the five year waiting period. Almost 294,000 children under age 19 were without health insurance in 2006-07. 76 percent of these (224,000 children) are income eligible for free or subsidized coverage through NJ FamilyCare or Medicaid) (45). Qualified immigrant parents with incomes less than 200% of the federal poverty level have been eligible for NJ FamilyCare (also without the five year residency requirement). Premiums are subsidized for qualified immigrant parents and children. (However, the proposed state budget for fiscal year 2010 freezes enrollment for parents with income between 150 percent and 200 percent of the federal poverty level.)

Those children with a family income above 350% of the federal poverty level qualify for a full cost buy-in to an SCHIP/CHIP expansion program called FamilyCare Advantage; there are no immigration restrictions for the FamilyCare Advantage buy-in (Horizon Blue Cross Blue Shield of NJ is the vendor providing this program under agreement with the state). An estimated 19 percent of New Jersey’s uninsured children (56,000 children) would be eligible for NJ FamilyCare Advantage (45). There are no subsidies or specified premium limits on NJ

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<sup>9</sup> These figures were supplied by the New Jersey Department of Human Services/DMAHS. Approximately 580,000 children and 228,000 adults are covered by the state, which includes Medicaid-covered parents and children, as well as those covered by NJ FamilyCare’s SCHIP (now CHIP) programs.

FamilyCare Advantage, which could pose questions of affordability for some income eligible families.

As noted above, new federal legislation and upcoming legislation will affect the outlook for health coverage of immigrants in New Jersey. The new CHIP reauthorization bill in the House gives states the option to remove the waiting period for legal immigrants and provide coverage for them with the federal matching funds. New Jersey has submitted state plan amendments for Medicaid and CHIP to cover pregnant women and children previously subject to the 5 year bar, effective April 1, 2009. New Jersey had been using only state funds to provide services for these women and children, and will now receive federal matching funds. New Jersey's SCHIP waiver that allowed parents and pregnant women to be covered under SCHIP was due to expire January 31, 2009, but has now been extended by the Centers for Medicare and Medicaid to September 30, 2011. Coverage for pregnant women under the SCHIP waiver is still set to expire June 30, 2009. To account for this, New Jersey has submitted a State Plan Amendment to move those women to coverage under CHIP (Title XXI) effective July 1, 2009.

Below, we summarize details of: coverage and programs for legal and undocumented immigrants in New Jersey, expected financial sustainability of the programs, the enrollment process, barriers to enrollment, safety net services, and efforts to address barriers.

#### **Coverage for legal immigrants**

- NJ FamilyCare removed the 5 year waiting period for legal immigrant children.
- New Jersey provides prenatal care with federal matching funds for legal immigrants who have been in the state for fewer than 5 years.
- Income-eligible immigrant children can buy into FamilyCare Advantage without subsidy

#### **Coverage for undocumented immigrants**

- Undocumented immigrants can only qualify for emergency Medicaid, no actual treatments
- The Supplemental Prenatal Care Program (SPCP) provides services for undocumented pregnant women. This money is given to FQHCs and hospitals (\$1.9 million to each)
- Undocumented, income-eligible immigrant children can buy in to FamilyCare Advantage without subsidy

#### **Financial sustainability**

- Child health mandate is expected to be expensive (a deficit program) but it is expected to be retained in the state budget.
- The CHIP reauthorization may provide the funds that will enable the state to continue to cover parents, provide grants for outreach and enrollment, and provide bonus payments for states that have embraced simplification efforts and express lane eligibility.
- Premise of NJ FamilyCare: "if parents are covered, more of the kids will be covered".

### **Enrollment process**

- New Jersey state officials are working on streamlining enrollment.
- Affiliated Computer Services (ACS) is the vendor for CHIP and Medicaid enrollment (including HMO selection). ACS does administrative renewals (meaning the individual does not have to re-apply for the program), by using data match from other data in state records. If residents' status is the same, they are kept in the program. This minimizes turnover (disenrollment/re-enrollment) in the programs.
- The Department of Human Services and Department of Health and Senior Services are working to develop a system to ensure that all eligible newborns are enrolled in NJ FamilyCare. New Jersey no longer offers Charity Care for newborns or children under 19. Instead, hospitals and FQHCs are encouraged to complete a Presumptive Eligibility application on the uninsured which establishes temporary Medicaid until a full Medicaid eligibility determination can be made. Also, a child born to a Medicaid enrolled mother is guaranteed one year of Medicaid eligibility.
- The new "Express Lane" application was implemented as of April 2009. The simplified application uses existing databases, such as obtaining income information from the taxation databases, in lieu of the family submitting support documentation.
- Also, if a resident indicated on 2008 state tax forms that the family has an uninsured child, this will trigger a mailing of the Express Lane application to the household.

### **Barriers to enrollment**

- Households with mixed immigrant status pose one of the greatest barriers to enrolling all eligible children in NJ FamilyCare or Medicaid. New Jersey state officials are strategizing with special interest groups that immigrants trust about ways to reach these households.

In addition to parents' fears:

- Currently no charity care is provided at hospitals to patients younger than 19 years, which means hospitals do not receive payment for those patients.
- The New Jersey residency requirement causes some issues because even legal immigrants with a visitor's visa are not New Jersey residents. However, adult hospital patients not eligible for NJ FamilyCare Presumptive Eligibility can be processed for Charity Care.
- Obtaining birth certificates for children born to undocumented immigrants in other states is a problem.
- Perceptions about health insurance: some immigrants do not perceive the need for health insurance in New Jersey because the health care systems in their home countries are socialized.

### **Safety net services for undocumented immigrants**

- FQHCs and emergency rooms provide care, but limited to prevention and primary care or acute problems. There is very little specialist care or surgical inpatient care available for this population.

- New Jersey’s Department of Health and Senior Services provides \$40 million a year to FQHCs to provide care to the uninsured. FQHCs are required to ask for proof of residency and income. A sliding scale of fees is charged.
- The state’s charity care program provides about \$600 million annually to New Jersey hospitals.
- “Free clinics” (often with a religious affiliation) provide care in some areas.

### **Efforts to address barriers to enrollment in New Jersey**

#### **Outreach, Enrollment and Retention Work Group**

PL 2008, C.38 provided for a \$1 million increase in funds dedicated to outreach and public awareness about NJ FamilyCare. It also established an *Outreach, Enrollment and Retention Work Group* to develop a comprehensive outreach plan to identify and enroll as many children as are eligible for state-sponsored coverage. This Work Group and its subcommittees met starting in September 2008, and released its report in May 2009. The report details the state’s efforts, including how the state has implemented or plans to implement several outreach initiatives that have been implemented in other states with expanded SCHIP programs (45).

Five subcommittees were organized, with broad based representation within and outside state government. State officials who were key informants feel this has been an extremely helpful effort, with a lot of input from a lot of different entities, and very worthwhile. The broad representation has brought out recommendations that have support from both state officials and stakeholders.

#### **Enrollment**

- ACS (the vendor for CHIP/Medicaid enrollment) started administrative renewals, which is more accurate and allows for less fraud because eligibility is checked against other state data records. Working with the counties to streamline the enrollment process.
- State officials are trying to build in enrollment where people access care. Medicaid and NJ FamilyCare will use “presumptive eligibility” when people receive services at FQHCs.
- The Department of Human Services is also working to identify databases that can be accessed for presumptive eligibility (Some state systems are not sophisticated enough to allow cross checking.) The aim is to minimize what ACS needs to qualify kids for enrollment - e.g.; eliminating the need for birth certificates.
- Hospitals are supporting measures to encourage parents with undocumented status to sign their children up for FamilyCare.
- Community organizations are allowed to file paperwork on their letterhead stating they know a parent who is undocumented and estimating their family income. This provides documentation of income information; the family can use this documentation in completing the application for enrolling a child in NJ FamilyCare.

## Outreach

- According to our key informants, NJ FamilyCare last did widespread advertising 5 years ago. In 2009, they have planned to do focus groups with parents to facilitate outreach to include specific ethnic groups. The strategy is to work with special interest groups that the parents have confidence in and trust
- NJ FamilyCare used to have a program of “grantees” that utilized community organizations as enrollment facilitators (see New York program, below). Grantees acted in the capacity of enrollment “coaches” and were paid \$25 for each successful application. HIPAA makes it more difficult to have grantees work with applicants, because of data sharing. The Office of Faith-Based Initiatives currently has 44 grantees that have added NJ FamilyCare outreach to their existing grant responsibilities.
- The Outreach subcommittee has worked on a process for next year in which the schools will identify which students are uninsured, so they can be given enrollment forms. The Work Group is considering this as a model that could use FQHCs, schools, and community based programs to do enrollment, now that the application is only one page.
- 2008 New Jersey state income tax form incorporated a question that enabled parents to report insurance status on dependent children. This will trigger the mailing of an Express Lane application to those households which identify uninsured dependents.

The state has a website that gives centralized information about public programs: [www.NJHelps.org](http://www.NJHelps.org), which allows residents to pre-screen for 28 separate government programs. Residents may apply online through this website for NJ FamilyCare and food stamps, but not New Jersey Family Care Advantage. The site also has links to other government websites for more information. NJ Helps has a link on the NJ FamilyCare website; it is run by the New Jersey Department of Human Services.

## Effect on health outcomes

At this time, there have been no longitudinal studies of individuals in the New Jersey SCHIP programs, but our key informants from New Jersey referred to research showing that having insurance will be beneficial to the health and well-being of those covered, especially to children (see also 45). New Jersey officials state that HEDIS measures<sup>10</sup> for public programs are improving in general, with percent of lead screenings and percent of dental care increasing.

- Prenatal care helps providers because every \$1 in prenatal care saves \$3 later
- They anticipate a healthier population
- All “unborn child” measures are improving, but it is really too early to tell overall program outcomes.

## Political sustainability

- The state has a mandate to cover every eligible child.

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<sup>10</sup> The Healthcare Effectiveness Data and Information Set (HEDIS) is a widely used set of performance measures in the managed care industry.



- State officials pointed out that budget issues may affect the political sustainability of expanded health coverage in New Jersey.
- The Working Group report (45) makes staffing and legislative recommendations to enhance the political sustainability of expanded health coverage.

**Health Coverage – Alternative State Models**

The states with the largest immigrant populations are California, New York, Texas, Florida, New Jersey, Illinois and Arizona. Three of these states – California, New York and Illinois - are in the forefront of coverage for immigrants, along with Massachusetts, which has reformed its entire approach to health coverage. Illinois has a unified program to cover all children; California, New York and Massachusetts cover low income immigrants through a patchwork of programs. To get an idea of the coverage available in these states, we conducted semi-structured interviews with experts in California, Illinois, Massachusetts, and New York. Below, we discuss each state’s coverage, based on our discussion with key informants (see Appendix A for a list of individuals interviewed for this report). In each section, we briefly describe the program, we list the coverage available for immigrants of legal and undocumented status, and we describe successful outreach and enrollment methods. (In Table 6, we summarize data on health coverage for immigrants in each of these states, as well as New Jersey and Pennsylvania, and in Table 7, we summarize outreach and enrollment methods in these states).

**Table 6. Coverage by State According to Immigration Status**

State	Documented Immigrants		Undocumented Immigrants		
	Children	Adults	Children	Pregnant women	Adults
California	✓	✓	✓	✓	
Illinois	✓		✓	✓	
Massachusetts	✓	✓	✓	✓	✓
New Jersey	✓	✓		✓	
New York	✓	✓	✓	✓	
Pennsylvania	✓	✓			

**Table 7. Outreach and Enrollment Methods**

State	Website with Programs Listed	Online Application	Single Point of Entry for Human Services Programs	Application Assistance Program
California	✓			✓
Illinois	✓	✓		✓
Massachusetts	✓	✓	✓	✓
New Jersey	✓	✓ *		
New York	✓	✓	✓	✓
Pennsylvania	✓	✓	✓	✓

\*New Jersey’s online application process is limited to certain programs; not completely interactive  
 Source: Tables 6-7 reflect data as of February 2009

**California**

Low income families in California are eligible for MediCal (its Medicaid program). “Healthy Families” is a Medicaid/SCHIP expansion program that is available to families who don’t meet income requirements for MediCal. In 2006, California passed legislation to combine MediCal and Healthy Families under the “Healthy Kids” umbrella. In certain counties or for emergency situations, immigrants with either legal or undocumented status may be eligible for Restricted MediCal, which can cover kidney dialysis, screening and treatment for breast and cervical cancer. The Access for Infants and Mothers (AIM) program, which is funded by the SCHIP unborn child option, is available for pregnant women.

The CaliforniaKids program is an option for children who do not qualify for other state programs, including those who are undocumented. It is financed and run by the CaliforniaKids Healthcare Foundation. CaliforniaKids covers over 62,000 children but doesn’t cover inpatient care. Premiums and copays are required, but depending on income, the Foundation provides subsidies.

In addition, California’s “Children Health Initiatives” (CHIs) are public-private partnerships that are used to cover additional children in certain California counties under Healthy Kids. CHIs obtain funding from private philanthropies, local and state contributions, and tobacco tax revenues to expand coverage for children who would not otherwise be eligible for public programs. This program is operated mainly by local and county governments. This allows for more flexibility but causes coverage to be disparate across the state. As of February 2009, 30 out of California’s 58 counties have CHIs. Nearly 90,000 children have been enrolled. Most CHIs have sliding scale payments, based on income. During interviews, policy experts have expressed concerns that fundraising is such a burden that these programs may not be sustainable.

### Coverage for Legal Status Immigrants

- MediCal
- Restricted MediCal
- Healthy Families
- Access for Infants and Mothers

### Coverage for Undocumented Status Immigrants

- Restricted MediCal
- Access for Infants and Mothers

### Successful Outreach and Enrollment Methods

California has implemented outreach and enrollment policies to ease new and continued enrollment. One example is the automatic enrollment of infants born to women on the Access for Infants and Mothers program in Healthy Families. Also, there is a presumptive eligibility process available to families with incomes up to 200 percent of the federal poverty level. Additionally, a recent policy allows families to submit applications for children's health coverage without submitting the first month's premium. The URL for this site is <http://www.ca.gov/Health/HealthCareServ/HealthInsurance.html>.

The CHIs also partner with local entities to provide outreach and enrollment of eligible children in MediCal, Healthy Families and Healthy Kids, depending on the location. Some CHI partners include local and community-based organizations, hospitals, schools, religious organizations.

### Illinois

Illinois' "AllKids" program is an umbrella program, which uses funding from SCHIP, Medicaid, and the state. By using state-only funds where necessary, AllKids includes undocumented immigrant children. All children in families with incomes up to 800% of the federal poverty level are eligible for state subsidies, which are determined by a sliding scale. AllKids has an estimated 1.8 million children enrolled, including approximately 60,000 children enrolled in the state-only funded portion. The program has an expected cost to the state of \$31 million per year, which is funded by cost savings generated from a Primary Care Case Management and Disease Management Program.

For adults, Illinois offers the FamilyCare program. This public coverage is available to low-income parents living with their dependent children. Illinois has two coverage programs for pregnant women: Medicaid Presumptive Eligibility (MPE) and Moms and Babies. MPE is temporary coverage for only outpatient health services, such as prenatal checkups, doctor visits, and medicine, to low income pregnant women. MPE does not cover labor and delivery. The Moms & Babies program covers both outpatient and inpatient services for women during pregnancy and for 60 days afterwards. It also covers care during babies' first year of life.

### Coverage for Legal Status Immigrants

- AllKids
- FamilyCare
- Medicaid Presumptive Eligibility
- Moms & Babies

### Coverage for Undocumented Status Immigrants

- AllKids
- Medicaid Presumptive Eligibility
- Moms & Babies

### Successful Outreach and Enrollment Methods

The simplicity of universal coverage for children has created an effective outreach strategy. In an interview, an Illinois policy expert explained that since “all” children are eligible, there is no longer the problem of parents assuming they make too much money and thus not signing up their children. Illinois has instituted an “application agent” initiative to improve outreach and enrollment. Application agents provide assistance to families who wish to enroll in AllKids. These agents include community-based organizations, day care centers, local governments, unions, medical providers, school districts, and insurance agents. Most application agents receive a \$50 Technical Assistance Payment (TAP) for each successfully enrolled child. The URL for this site is <http://www.hfs.illinois.gov/> and <http://www.allkids.com/>.

### **Massachusetts**

In 2006, Massachusetts enacted an extensive reform of health coverage in the state, with several components. The “Commonwealth Care” program is an SCHIP/Medicaid expansion that is available for families with incomes up to 300% of the federal poverty level. The private insurance program is “Commonwealth Choice”, which includes private health insurance options approved by the state. Some subsidies are available to residents for these policies. Those who are ineligible for Commonwealth Care (including undocumented immigrants) and cannot afford Commonwealth Choice are eligible for the Massachusetts Health Safety Net, a coverage program for low income residents. This only covers care at hospitals, hospital clinics, and Federally Qualified Health Centers. The Children’s Medical Security Plan (CMSP) covers all children regardless of immigration status or income. This plan only covers primary and preventive care—not hospitalization costs. Low income families of children covered by the CMSP are eligible for premium subsidies.

### Coverage for Legal Status Immigrants

- Commonwealth Care
- Commonwealth Choice
- Health Safety Net
- Children’s Medical Security Plan

### Coverage for Undocumented Status Immigrants

- Health Safety Net
- Children’s Medical Security Plan

### Successful Outreach and Enrollment Methods

Massachusetts is in the unique position of having an individual health coverage mandate as an outreach mechanism. However, the mandate does not apply to children. A Massachusetts policy expert explained that the state thought the adult mandate and subsidies would be enough of an incentive for adults to get their children health coverage.

Additionally, the state has established the Commonwealth Connector, which is a website where residents and employers can compare insurance programs and obtain coverage. By entering income information into this website, residents can also learn if they are available for free or subsidized coverage. The URL for this site is <http://www.mahealthconnector.org/portal/site/connector/>.

The Massachusetts FY2009 budget allocates an additional \$3.5 million for an outreach grant program. This program will award grants to community and consumer-focused public and private non-profit organizations for outreach, enrollment, application assistance, educating new enrollees on how to use their health insurance, and the importance of preventive care.

### New York

In New York, low income adults may be eligible for coverage through Medicaid and “Family Health Plus”. Children in low income families are eligible for either Children’s Medicaid or “Child Health Plus”. Family Health Plus and Child Health Plus are SCHIP expansion programs. Cost sharing depends on income, with families earning less than 1.6 times the Federal Poverty Level covered at no cost. Pregnant women may be eligible for prenatal care coverage through the Prenatal Care Assistance Program (PCAP).

In New York, two programs do not require proof of citizenship or immigration status. Pregnant women are eligible for PCAP as long as they have proof of New York residency and meet income requirements. If parents wish to obtain Child Health Plus coverage for their children, they do not need to prove citizenship or immigration status of the child.

### Coverage for Legal Status Immigrants

- Medicaid
- Family Health Plus
- Children’s Medicaid
- Child Health Plus
- Prenatal Care Assistance Program

### Coverage for Undocumented Status Immigrants

- Child Health Plus
- Prenatal Care Assistance Program

### Successful Outreach and Enrollment Methods

The “facilitated enrollment” program in New York has been a successful way to extend outreach and enrollment throughout the state. Community based organizations frequently serve as facilitators that help people apply and enroll in public programs. This program is especially successful because it allows working people to obtain enrollment assistance during weekends and evenings. Also, these facilitation efforts satisfy the face-to-face interview requirement for Medicaid and SCHIP.

New York has also implemented policies to simplify the enrollment process. For example, families are no longer required to show proof of income when enrolling or renewing public coverage. New York also has presumptive eligibility for children enrolled by qualified entities, such as schools, hospitals, and community health clinics.

New York’s Department of Health website clearly lists all available public health insurance programs and their respective eligibility requirements. The URL for this site is [http://www.nyc.gov/html/hia/html/public\\_insurance/public\\_insurance.shtml](http://www.nyc.gov/html/hia/html/public_insurance/public_insurance.shtml).

Alternatively, the Access New York website allows residents to input their information, determine eligibility for over 30 public programs, and apply for services. Residents can either anonymously determine eligibility or set up an account.

### Pennsylvania

Children may be eligible for Pennsylvania CHIP, an SCHIP expansion. Copayments and premiums range from free for lower income children to a full cost buy in for higher income children. As of January, 2009, 183,891 children were enrolled in the Pennsylvania CHIP program. Pennsylvania Medical Assistance (Medicaid) provides coverage to certain low income residents either through HealthChoices, a managed care program, or Fee-For-Service. Through Medical Assistance, pregnant women may be eligible for Healthy Beginnings, which covers prenatal care, child birth, and care for the baby for 60 days. AdultBasic, a public coverage program funded by a tobacco settlement, covers most basic services. As of February, 2009 approximately 1.9 million residents were covered under Medical Assistance and over 90,000 residents were enrolled in Adult Basic. “Cover All Kids”, which was launched in 2006, recently expanded coverage to include all eligible children regardless of income (and using state funds only to provide coverage for legal status immigrants regardless of time in country; this does not include undocumented immigrants).

### Coverage for Legal Status Immigrants

- CHIP
- Medical Assistance

- Healthy Beginnings
- AdultBasic

#### Coverage for Undocumented Status Immigrants

- Labor and delivery may be covered under Emergency Medicaid

#### Successful Outreach and Enrollment Methods

The Pennsylvania COMPASS website allows Pennsylvanians residents to determine their eligibility, apply for, and renew many health and human services on one website. The URL for this site is <https://www.humanservices.state.pa.us/compass/CMHOM.aspx>.

COMPASS uses Community Partners to help residents submit applications for benefits. Current Community Partners are community-based agencies, organizations, coalitions, hospitals, church groups and other groups. “Cover All Kids”, includes an outreach initiative. Similar to the program in Illinois, expanding eligibility to remove income qualifications obviates the problem of parents not signing their children up because they think they make too much money. (Unlike Illinois, the Pennsylvania program is not open to undocumented immigrants.)

## **Conclusion**

Studies of immigrants’ insurance status show that their health coverage changes over time, suggesting that health coverage programs should take this progression into account. The longer immigrants live in the U.S., the more likely they are to be insured. Also, while immigrants are more likely to be uninsured, those who are naturalized citizens are more likely to be insured than non-citizens. In addition, among those immigrants who have health coverage, more have private insurance than public coverage (27). The problem with lack of insurance is not primarily a problem of immigrants. Although immigrants are more likely to be uninsured, only one-quarter of the U.S. uninsured are non-citizens. Moreover, between 2000 and 2006 there was a slight gain in the number of immigrants who had health coverage (20).

Immigrants in each of the profiled states face the same barriers, but the states have tried some variations on addressing these barriers. In terms of eligibility, Illinois has reached the furthest, in making all children eligible for a unified program of public coverage, regardless of immigration status. California, New York and Massachusetts provide coverage for children, regardless of immigration status, but it is provided through a patchwork of programs. This makes the process of enrollment that much more cumbersome. Pennsylvania has created an expanded SCHIP program for “all” children, much like NJ FamilyCare, but it is restricted to citizens and legal immigrants.

New Jersey faces a serious challenge, because of the characteristics of its immigrant population. The population is diverse, including many immigrants who are highly educated and skilled, who work in positions providing private health insurance. Many other immigrants, legal and undocumented, work in positions providing little or no private coverage. The public coverage

available reflects a patchwork of programs, eligibility and income requirements. Many of the same problems confront the uninsured in general, not only immigrants. Culturally attuned outreach efforts and improved enrollment processes will continue to be critical factors in the success of any public program to cover immigrants and their children.

A number of high immigration states, including New Jersey, are attempting to provide greater outreach and cover more of their immigrant residents. Each state provides a slightly different policy alternative, but the most comprehensive coverage in these states is available to children of immigrants, particularly citizens and legal immigrants. Recently passed federal legislation is expected to increase the coverage available through these programs. New Jersey is among the group of states with high immigrant populations that provide comparatively more public coverage and safety net programs.<sup>11</sup> However, compared to other states with large immigrant populations and similar state economic circumstances, New Jersey has not been a leader. The passage of last year's New Jersey health legislation (PL 2008, C.38 / S1557 3R), and the efforts of the resulting Outreach, Enrollment and Retention Work Group, could offer the state an opportunity to improve coverage for immigrants.

The coverage of immigrant adults, particularly undocumented adults and those without children remains an unmet need. The overall quandary of immigration is a national policy issue, requiring a political resolution at the federal level. In the more immediate future, New Jersey faces continuing questions of affordability of its expanded coverage for low-income children and their parents, including immigrants. Maintaining the course of this expanded coverage in the face of severe state budget constraints is New Jersey's challenge.

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<sup>11</sup> Covering legal immigrants with state funds in the 5 year waiting period was cited by our New Jersey informants as one of the state's most positive efforts.



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## Appendix A: Individuals Interviewed

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<i>Key Informant</i>	<i>Organization</i>
Tanya Broder	National Immigration Law Center, California
Shannon McConville	Public Policy Institute of California
Vicky Pulos	Massachusetts Law Reform Institute
Jenny Rejeske	New York Immigration Coalition
John Guhl	Division of Medical Assistance and Health Services, New Jersey
Heidi Smith, Director	New Jersey Family Care
Carol Grant, Director	Division of Developmental Disabilities, New Jersey
Elena Josephick, Administrator	Division of Medical Assistance and Health Services, New Jersey
John Bouman	Sargent Shriver National Center on Poverty Law, Illinois
Leighton Ku	George Washington University School of Public Health and Health Services
Susan Sherry	Community Catalyst
Stephen Larson	University of Pennsylvania

## **Appendix B: CVC Leadership – Attendees at Roundtable October 22, 2008**

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<i><b>Participant</b></i>	<i><b>Organization</b></i>
Lynda Carson	NJ Coalition for Battered Women
Christopher Irizarry	North Hudson Community Action Program
Marlene Lao-Collins	NJ Catholic Charities
Ev Liebman	NJ Citizen Action
Sarah McLallen	Health Care Quality Institute
Daniel Santo Pietro	Hispanic Directors Association
Leo Torrey	NJ Citizen Action
Eve Weissman	NJ Citizen Action



## Appendix C: Program Eligibility and Limitations on Coverage Available to Immigrants – 1996-2009

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Various states, including New Jersey, have sought ways to address coverage for immigrants within the limitations that were set by federal legislation. This suggests the efforts that some of those states will take over the next few years, under the new CHIP rules and other terms of health reform. Since 1996, there have been serious limitations on coverage, even for immigrants with legal status. The Personal Responsibility and Work Opportunity Reconciliation Act (known as PRWORA) removed federal matching funds to cover documented immigrants under public health insurance programs during their first five years in the country. The exception to this has been emergency Medicaid coverage, which is available to low-income individuals in each state, regardless of immigration status.<sup>12</sup> In addition, since 1996, a number of states have chosen to use exclusively state dollars to cover documented immigrants within their first five years of U.S. residency (Table 5). In particular, states have chosen to expand their SCHIP, because the importance and cost-effectiveness of child health is widely recognized, and because it is politically feasible to address coverage for low-income children, whether they are immigrant or native born. A number of outreach and enrollment initiatives have accompanied these expanded SCHIPs: media campaigns; partnering with schools, community based organizations and advocacy groups; simplifying enrollment processes and forms; using income and other personal information from existing data systems to assist in enrollment; linking to other assistance programs (such as free and reduced price school lunches) to identify eligible children; using state tax forms to identify eligible families (50).

### Medicaid coverage for immigrants

Citizens who meet financial criteria are eligible for Medicaid coverage if they are in one of the following groups: children, parents with dependent children, pregnant women, people with severe disabilities, and the elderly. Medicaid is funded by the state with a specified match from the federal government.

### SCHIP coverage for immigrants

In 1998, the State Children's Health Insurance Program (SCHIP) was enacted with bipartisan support as part of the Balanced Budget Act (BBA). Unlike Medicaid, SCHIP is not an entitlement program, but rather a federal program that provides a capped amount of money to states to support health care coverage to uninsured children. . Citizen children in families with low incomes are eligible for SCHIP federal matching funds, but the states determine how to allocate the federal grant. States have some flexibility over how to use the funds through federal waivers. However certain options are available to states without a waiver, such as expanding

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<sup>12</sup> States vary a great deal in deciding which services they will cover under Emergency Medicaid. This is a complicated area, with "limited federal guidelines". For example, California, New York and North Carolina will cover dialysis for undocumented immigrants to prevent the need for emergency dialysis (71).

eligibility to parents, to children in families with higher incomes, and to pregnant women (regardless of immigrant status) through the SCHIP “unborn child option”. As shown in Table 5, thirteen states have been providing prenatal care under this option.

#### State-only funded coverage for immigrants

As shown in Table 5, seventeen states (including New Jersey) have been using state-only funds (without any federal match) in order to provide coverage for children with legal status within the first five years of U.S. residency. Eleven states (including New Jersey) have been providing state-only funded services for some adults with legal status within the first five years.

Approximately six states cover children with undocumented status using only state funds.

Additional states had provided this coverage, but have withdrawn such coverage because of economic constraints.