



## Policy Brief

### Consequences Of Eliminating Health Benefits For Lawfully Residing Immigrants

April 2009

Proposed Medicaid changes:  
Second in a series

#### IN SUMMARY

- Governor M. Jodi Rell's proposal would terminate Connecticut's program providing health benefits to nearly 6,000 immigrants lawfully residing in the United States less than five years. The vast majority of current participants would likely become uninsured.
- Federal legislation enacted this year allows Connecticut to obtain federal matching funds that should pay roughly \$10 million of the \$48 million cost of this program over two years, if the program is retained.
- Research shows immigrant children or pregnant women who become uninsured are far less likely to have a regular source of care, or get well-child or prenatal care and more likely to seek emergency room care. The state then pays for at least a share of labor and delivery, and other emergency services because of Medicaid requirements.
- Safety-net providers, such as community health centers, are a key source of care for low-income immigrants. Terminating coverage will add challenges for these providers, especially while they face other budget cuts.

#### OVERVIEW

*On February 4, 2009, Governor M. Jodi Rell proposed eliminating a state-funded program that provides health benefits to nearly 6,000 individuals lawfully residing in the United States for less than five years.*

That same day, President Barack Obama signed the Children's Health Insurance Program Reauthorization Act (CHIPRA), which allows states to use federal matching funds to cover many of these individuals under Medicaid and CHIP. CHIPRA lifts a 1996-enacted ban on using federal dollars for lawfully residing immigrant children and pregnant women.

If Connecticut accepts this new federal option, not only will affected children and pregnant women retain health coverage, but also federal dollars will replace about one-fifth of state dollars currently paying for this program. If it terminates the program, most participants will become uninsured and lose access to basic health services. The state will then have to pay for emergency care and safety-net providers may lose payments for services provided.

As of February 2009, the state provides health services to nearly 6,000 lawfully residing immigrants, including about 2,300 children age 18 and under. If coverage is terminated:

- Most will become uninsured.
- Many health needs will go unmet.

When those without coverage seek emergency care:

- Costs will be higher.
- The state will be responsible for a substantial share of those costs.

Regardless of the new proposal's outcome, another 15,000 immigrants lawfully residing in the United States longer than five years will remain eligible for state and federally funded Medicaid coverage.



## ABOUT HUSKY

HUSKY provides health insurance for nearly 350,000 Connecticut children and parents.

- HUSKY A is Connecticut's Medicaid program for low-income families.
- HUSKY B is the state's CHIP for children in families with incomes too high to qualify for HUSKY A.

The federal government matches funds covering 50 percent of HUSKY A costs and 65 percent of HUSKY B. The HUSKY A matching rate increases temporarily under the federal stimulus legislation.

Connecticut covers certain immigrants through the State Medical Assistance to Non-Citizens (SMANC) program, created in 1997. SMANC uses only state dollars because federal welfare reform legislation restricted participation in federally funded means-tested programs, such as Medicaid and CHIP (with some exceptions). Undocumented (illegal) immigrants are ineligible for these programs.<sup>1</sup>

For more information, see "HUSKY At a Glance," Connecticut Voices for Children, February 2009.

## WITHOUT COVERAGE, GETTING HEALTH CARE CAN BE CHALLENGING

Without health coverage, lawfully residing immigrant children and pregnant women typically fail to seek needed health care, including immunizations and prenatal care. When they obtain treatment from a safety-net provider, such as a community health center, the provider receives no payment.

From 1995 to 2006, Medicaid expansions and the creation of CHIP reduced the uninsured rate for low-income citizen children from 19 percent to 15 percent nationally. But in that period, the already-high uninsured rate for noncitizen immigrant children rose from 44 percent to 49 percent.<sup>2</sup>

When immigrant children become uninsured, research shows they are much less likely to:

- Have a regular source of care
- See a primary care doctor
- Have a well-child visit

As a result, their families:

- Defer care for their children as long as possible
- Use the emergency room more often when they finally seek care

One study showed that 52 percent of low-income immigrant children with insurance had a well-child visit in the course of a year, compared to 30 percent of those without insurance.<sup>3</sup>

Another study compared care for pregnant women in New York (which used state funds to preserve coverage for lawfully residing immigrants) with Florida (which dropped coverage after the 1996 federal law change). The study found that pregnant Hispanic women who were lawfully residing immigrants in New York were considerably more likely than those in Florida to obtain prenatal care.<sup>4</sup>

Uninsured families seek emergency care for conditions that could have been treated in a less expensive primary care setting. A family brings an uninsured child to the emergency room with uncontrolled asthma or flu symptoms, or a woman without adequate prenatal care gives birth to a preterm or low-birth-weight baby. Costs for emergency services and subsequent care accrue as uncompensated care for the hospital if not paid by the state under emergency Medicaid coverage. This result might have been avoided if the child or pregnant woman had access to primary care.

A California study found that every \$1 cut from prenatal care led to an increase of \$3.33 for additional postnatal care, such as services in the neonatal intensive care unit (NICU). For every \$1 cut, preterm births also led to an additional \$4.63 in the incremental cost of health care, child care and special education from birth to age 15.<sup>5</sup> Although this study used data on undocumented immigrants, the same patterns likely apply to lawfully residing immigrants unable to obtain primary care and prenatal services.

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## STATES AND PROVIDERS HELP PICK UP THE TAB FOR UNINSURED IMMIGRANTS

Cutting coverage for lawfully residing immigrants does not relieve the state of all costs for their care.

Because Medicaid covers emergency medical care, including childbirth, for all immigrants not eligible for full coverage, the state pays a share of the costs when patients unnecessarily seek emergency care.

Moreover, infants born in Connecticut to immigrant mothers are U.S. citizens and likely eligible for HUSKY. Thus, state and federal dollars will pay for the baby's health costs, including expensive NICU services.

The state also may incur long-range costs for immigrant children who eventually qualify for Medicaid as citizens or permanent residents.

One effect of eliminating coverage for low-income residents is greater reliance on safety-net providers, including federally qualified health centers (FQHCs). A 2002 survey found that one-sixth of FQHC patients nationally were immigrants and the share has probably grown since then.<sup>6</sup>

Connecticut FQHCs served more than 226,000 in 2006, nearly one in every 25

state residents. About one-third of FQHC clients are uninsured and the centers provide primary care for over one-fourth of Connecticut's Medicaid population.<sup>7</sup>

Federal grants help fund health center services for those uninsured. But the centers are better able to serve the uninsured when more of their clients have Medicaid, because Medicaid pays the centers for these services.

## STATE PROGRAMS AND AN OPPORTUNITY FROM NEW FEDERAL LEGISLATION

By removing the five-year waiting period for lawfully residing children and pregnant women who enroll in Medicaid or CHIP, CHIPRA allows states that cover recent lawfully residing immigrants to replace a majority of state dollars they now use with federal dollars. By choosing that option, Connecticut would receive the enhanced CHIP matching rate (65 percent) for covering immigrant children in both HUSKY A and HUSKY B. For pregnant women, Connecticut would receive the Medicaid matching rate, increased to at least 60 percent by recent federal stimulus legislation.<sup>8</sup>

Connecticut is one of 21 states that cover at least some lawfully residing immigrant children excluded from Medicaid coverage because they have

lawfully resided in the United States less than five years. It is one of 16 states that cover pregnant women who are recent lawfully residing immigrants. Connecticut's programs, like the others, are fully paid for with state funds without benefit of federal matching funds available for Medicaid and CHIP.<sup>9</sup>

By opting to shift about 2,500 children and pregnant women to HUSKY coverage, Connecticut would collect about \$10 million in federal matching funds to replace state dollars. This estimate assumes that spending on these individuals, whose health care may cost less on average than that of participating parents, represents about one-third of the \$50 million two-year savings estimate for eliminating this program.<sup>10</sup>

The remaining 3,400 noncitizen participants are mostly parents, some of whom may have children who are U.S. citizens because they were born here. About 300 participants are eligible based on age or disability.

Neither group would become eligible for Medicaid based on the new federal law. But continued coverage with state funds would avoid disruption to their health care and maintain the ability of safety-net providers to serve them. Continued coverage for lawfully residing parents allows them not only to maintain their own health, but also to stay in the workforce and help keep their children healthy and enrolled in HUSKY.

## FOOTNOTES

1 Under federal law, illegal immigrants may receive emergency medical services (including labor and delivery) provided in settings such as emergency rooms, hospital critical care units and intensive care units. These emergency services are covered with state and federal matching dollars through the Emergency Medicaid program.

2 Leighton Ku, "Restoring Medicaid and SCHIP Coverage to Legal Immigrant Children and Pregnant Women: Implications for Community Health and Health Care for Tomorrow's Citizens," Department of Health Policy, George Washington University, January 13, 2009.

3 Leighton Ku, "Restoring Medicaid and SCHIP Coverage to Legal Immigrant Children and Pregnant Women: Implications for Community Health and Health Care for Tomorrow's Citizens," Department of Health Policy, George Washington University, January 13, 2009; Samantha Artiga and Karyn Schwartz, "Health Insurance Coverage and Access to Care for Low-Income Non-Citizen Children," Kaiser Commission on Medicaid and the Uninsured, May 2007.

4 Elena Fuentes-Affleck et al., "Use of Prenatal Care by Hispanic Women after Welfare Reform," *Obstetrics and Gynecology* 107(1): 151-160, January 2006.

5 Michael C. Lu et al., "Elimination of Public Funding of Prenatal Care for Undocumented Immigrants in California: A Cost/Benefit Analysis," *American Journal of Obstetrics and Gynecology* 182, part 2, no. 1 (January 2000): 233-239.

6 Leighton Ku, "Restoring Medicaid and SCHIP Coverage to Legal Immigrant Children and Pregnant Women: Implications for Community Health and Health Care for Tomorrow's Citizens," Department of Health Policy, George Washington University, January 13, 2009.

7 Connecticut Primary Care Association, FQHC Facts, <http://www.chcact.org/cms/storage/file/FQHC%20facts.pdf>.

8 Under the terms of CHIPRA, immigrant children would be covered at the enhanced matching rate, corresponding to CHIP coverage, regardless of the family's income level.

9 Leighton Ku, "Restoring Medicaid and SCHIP Coverage to Legal Immigrant Children and Pregnant Women: Implications for Community Health and Health Care for Tomorrow's Citizens," Department of Health Policy, George Washington University, January 13, 2009.

10 State data for February 2009 show that 39 percent (2,323 of 5,971) of program participants are children. Another 201 are pregnant women — making a total of 42 percent of all program participants.



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## MORE INFORMATION

This brief and others in this series are available on our website at [www.cthealth.org](http://www.cthealth.org) or by calling 860.224.2200.

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## CONCLUSION

Just when the federal government offers states federal matching dollars for coverage Connecticut already provides, Gov. Rell has proposed terminating health coverage for recent lawfully residing immigrants. Connecticut could bring in about \$10 million by choosing the option to cover this group in HUSKY as a result of the recently signed CHIPRA law.

Many of the 6,000 currently covered with state-only funds likely will become uninsured if the program is terminated. Without insurance, many will lack a regular source of care and fail to receive well-child care, prenatal care or other primary care services.

If they seek emergency room care, the state will pay part of the cost under Medicaid's coverage of emergency services. In effect, the state pays the higher cost associated with emergency care or preterm labor and delivery instead of investing in primary or prenatal care.

Furthermore, if babies are born prematurely, not only will the birth be covered as an emergency service, but also the child will be born a U.S. citizen and most likely be eligible for HUSKY. If so, Connecticut will be responsible for a share of NICU costs and other services.



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