RESEARCH REPORT

Immigrant Access to Health and Human Services

Final Report

Edited by Julia Gelatt and Heather Koball

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This report includes material drawn from the seven briefs and one policy report produced as part of the Immigrant Access to Health and Human Services project, which maps and describes the legal and policy contexts that govern and affect immigrant access to health and human services. Through a synthesis of existing information, supplemented by in-depth visits to purposively selected sites, the study aims to identify and describe federal, state, and local program eligibility provisions related to immigrants; major barriers (such as language and family structure) to immigrants’ access to health and human services for which they are legally eligible; and innovative or promising practices that can help states manage their programs.

The information presented here was gathered by the following team of researchers: Robert Crosnoe, Karina Fortuny, Julia Gelatt, Devlin Hanson, Michael Huntress, Genevieve M. Kenney, Heather Koball, Juan Manuel Pedroza, Krista M. Perreira, Kelly Purtell, Kjersti Ulvestad, Christina Weiland, Hirokazu Yoshikawa, and Ajay Chaudry, who contributed to this work while at the Urban Institute. This final report was prepared by Julia Gelatt and Heather Koball. We are grateful to our many colleagues at the Urban Institute who provided assistance and feedback throughout this project and to David Nielsen from the Office of the Assistant Secretary for Planning and Evaluation at the Department of Health and Human Services for his thoughtful comments and guidance on the prior products in this series and on this final report. We appreciate the editorial assistance of Ashleigh Rich and Fiona Blackshaw, and the production assistance of Scott Forrey, David Connell, and Leigh Franke.

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Immigrant Access to Health and Human Services

Introduction

The foreign-born population of the United States has grown quickly over the past several decades, increasing from 20 million in 1990 to 40 million, or about 13 percent of the US population, in 2010 (US Census Bureau 1990, 2000, 2011). (See appendix A for a definition of terms, including the difference between “foreign-born” and “immigrant” as used in this report.) Further, about 17 million children in the country have at least one foreign-born parent; of these, a little over 2 million are themselves foreign-born. That is, nearly all (87 percent) children with foreign-born parents are themselves US-born citizens. Immigrant families are disproportionately likely to have low incomes. About 23 percent of children living with at least one foreign-born parent have incomes below the poverty level, compared with 16 percent of children living with only US-native parents. Thirty-seven percent of children with only immigrant parents live below the poverty level (Hanson et al. 2014).

Several federal programs provide assistance to low-income US families, most notably Medicaid, the Children’s Health Insurance Program (CHIP), the Supplemental Nutrition Assistance Program (SNAP), and the Temporary Assistance for Needy Families (TANF) program. Evidence demonstrates that these programs reduce hardship, increase family stability, and contribute to better health and nutrition for children (Perreira et al. 2012). Immigrant families may be particularly likely to meet income eligibility criteria for these programs but, for various reasons, they are less likely than other families to access them.

In this final report, we summarize the main findings of the seven briefs and one previous report that make up the Immigrant Access to Health and Human Services project. This project explores the legal and policy contexts that govern and shape immigrants’ access to major federal health and human services programs. We begin with an overview of the federal and state policies that shape immigrant families’ eligibility for programs, along with their actual benefit receipt rates across the country. We then summarize policies related to California’s implementation of the Patient Protection and Affordable Care Act (ACA) and the possible implications of those policies for immigrants in the state. California serves as a useful example of how state decisions under the ACA may affect immigrants.
Finally, we share the results of our in-depth exploration of immigrant access to benefits in Maryland, Massachusetts, North Carolina, and Texas. Our research in these states yields findings on policy and other barriers immigrants face to accessing benefits and on promising practices that are helping to improve access, with particular emphasis on the importance of community-based organizations.

All products under this project are available at http://aspe.hhs.gov/hsp/11/ImmigrantAccess/ and http://www.urban.org/immigrants/immigrant-access.cfm. Appendix B summarizes the methods employed in these studies.

Immigrant Eligibility for Federally Funded SNAP, TANF, Medicaid, and CHIP

Current federal eligibility for health and human services was largely set in 1996 by the Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA), often referred to simply as “welfare reform.” This bill set limits on how states could use federal funding to provide benefits to different categories of immigrants, based on immigration status, age, year of entry to the United States, and length of residence in the country. As a first step in determining benefits eligibility, PRWORA divided immigrants into two main categories of benefits eligibility: qualified and nonqualified. Qualified immigrants include lawful permanent residents (LPRs) and certain other legal immigrants, while nonqualified immigrants include unauthorized immigrants and some legal temporary immigrants. For more detail on who is included in each category, see A Comprehensive Review of Immigrant Access to Health and Human Services, particularly page 4 (Fortuny and Chaudry 2011).

PRWORA then set additional limits on eligibility for certain qualified immigrants. Most important, LPRs and other qualified immigrants who arrived to the United States after 1996 have limited eligibility for federally funded public benefits during their first five years of qualified status. This five-year waiting period is often called the five-year ban. Qualified immigrants are generally eligible for federally funded SNAP, TANF, Medicaid, and CHIP only after their first five years of qualified status, and even then, they are eligible for TANF, Medicaid, and CHIP only if they live in a state that has decided to provide these federally funded benefits to immigrants. Policies are more generous for immigrant children. Since 2002, qualified immigrant children have been eligible for federally funded SNAP even during their first five years of qualified status; since 2009, states have had the option of providing federally funded Medicaid and CHIP to lawfully present children and pregnant women even during their first five years.
State Policies on Immigrant Eligibility for Health and Human Services

Within federal rules, states face several options about which categories of immigrants to cover under which benefits. States can decide (1) whether to provide federally funded TANF and federal-state jointly funded Medicaid to qualified immigrants after the five-year ban, (2) whether to provide federal-state jointly funded Medicaid and CHIP benefits to children and pregnant women during their first five years as lawfully present immigrants, and (3) whether to use state funds to provide benefits to qualified immigrants during the federal five-year ban, or to assist nonqualified immigrants. Below we briefly outline the choices that states had made at the time of our examination. More detail is available in *A Comprehensive Review of Immigrant Access to Health and Human Services* (Fortuny and Chaudry 2011).

**Federally funded TANF and Medicaid after the five-year ban.** Most states have opted to provide TANF, Medicaid, and CHIP to qualified immigrants after the five-year ban. As of July 2009, only North Dakota and Mississippi did not extend TANF to at least some categories of qualified immigrants after the five-year ban. As of 2010, only seven states did not provide Medicaid to most qualified immigrants after the five-year ban.

**Federally funded Medicaid and CHIP to children and pregnant women during the first five years.** Many states have also taken up the option to provide public health insurance (Medicaid and CHIP) to children and pregnant women during their first five years of lawfully present status. As of March 2011, 22 states had chosen to provide federal-state jointly funded Medicaid and CHIP to lawfully present children or pregnant women during the five-year ban. Figure 1 illustrates which states cover children, pregnant women, or both under Medicaid and CHIP.
**FIGURE 1**
Availability of Federally Funded and State-Funded Medicaid and CHIP to Pregnant Women and Children during First Five Years of Lawfully Present Status, 2011

State-funded benefits during the five-year ban and for nonqualified immigrants. Several states have also opted to use state funding to provide public benefits to qualified immigrants during the five-year ban or to nonqualified immigrants who are ineligible for federally funded cash, food, and health insurance assistance. As of March 2011, 14 states and the District of Columbia had chosen to use state funds to provide public insurance to qualified immigrants (other than pregnant women and children) during the five-year ban, and 16 states and the District of Columbia had elected to use state funds to provide coverage to some select categories of nonqualified immigrants. Figure 2 shows which states provide state-funded public health insurance for nonqualified immigrants (Fortuny and Chaudry 2011, 2012).
Seven states have chosen to use state funds to provide food assistance to immigrants ineligible for federal SNAP. Figure 3 shows which states provide state-funded food assistance to at least some categories of immigrants who are ineligible for SNAP. In addition, as of July 2009, 22 states provided state-funded cash assistance to some qualified immigrants during the five-year ban, and 5 states provided state-funded cash assistance to some nonqualified immigrants. Figure 4 shows the 22 states that provide state-funded cash assistance to qualified immigrants during the five-year ban.
**FIGURE 3**
States Providing State-Funded Food Assistance to Immigrants Ineligible for Federally Funded SNAP, 2011

Source: Fortuny and Chaudry (2012).

**FIGURE 4**
States Providing State-Funded Cash Assistance to Immigrants during Five-Year Ban, 2009

Source: Fortuny and Chaudry (2012).
Rates of Program Use

Federal and state policies, combined with other barriers outlined below, shape immigrant families’ ability and willingness to access public benefits. We have outlined immigrant families’ receipt rates for the four major benefit programs: SNAP, TANF, Medicaid, and CHIP. These rates were determined by analyzing data from the 2008 and 2009 American Community Survey. We calculated rates separately for (1) children with native (US-born) parents, (2) citizen children with naturalized-citizen parents, (3) citizen children with mixed-citizenship parents, (4) citizen children with only noncitizen parents, and (5) noncitizen children. More information on these rates is available in the briefs entitled “Low-Income Immigrant Families’ Access to SNAP and TANF” and “The Affordable Care Act: Coverage Implications and Issues of Immigrant Families” (Hanson et al. 2014; Kenney and Huntress 2012).

**SNAP.** Immigrant families are less likely to receive SNAP than native families. In this project, we focus particularly on access to food assistance among children with foreign-born parents. While over two-thirds (69 percent) of children in poor families with US-born parents received SNAP in 2008 and 2009, less than half (47 percent) of children in poor families with foreign-born parents received SNAP. Rates of SNAP receipt are particularly low for immigrant children in poor families: about 37 percent received SNAP in 2008 and 2009. In all but five states, children in poor families with foreign-born parents have lower rates of SNAP receipt than those with US-born parents, with varying degrees of disparity across states (Hanson et al. 2014).

**TANF.** Overall TANF receipt rates are lower than rates of SNAP receipt, so the differences between native and foreign-born families’ receipt rates are smaller. In poor families, about 18 percent of children with native parents received TANF in 2008 and 2009, compared with about 12 percent of children with foreign-born parents. In just four states, children in poor families have similar TANF receipt rates whether their parents are foreign-born or US-born; only in Minnesota are children with foreign-born parents more likely to receive TANF than those with US-born parents (Hanson et al. 2014).

**Medicaid and CHIP.** Children in poor families with foreign-born parents have lower rates of public health insurance coverage than those with US-born parents. Among children in poor families, 77 percent of those with US-born parents and 69 percent of those with foreign-born parents had Medicaid or CHIP coverage in 2008 and 2009. Looking more broadly at immigrants of all ages, gaps in health insurance coverage are even wider. In the United States as a whole, slightly over half (51 percent) of noncitizen nonelderly adults are uninsured, compared with 17.6 percent of US-citizen adults (including US-born citizens and foreign-born naturalized citizens). This disparity is driven by gaps in rates of both
private and public insurance coverage. Only 35 percent of noncitizen nonelderly adults have employer-sponsored insurance, compared with 65 percent of US-citizen adults (Kenney and Huntress 2012).

Changes to Health Insurance Policy under the Affordable Care Act

The implementation of the ACA has brought some changes to federal and state health insurance policies. Under this project, we examined California as a case study to help better understand how state decisions could affect immigrants' access to health insurance under the ACA. We selected California because it has the largest immigrant population in the country, and because it has been an early implementer of the ACA. Information on California is based on February 2013 discussions with public agencies, community-based organizations (CBOs), and advocates in California. During a site visit to California, we also collected information on what has worked well for connecting eligible immigrants to health insurance and on remaining challenges. Two briefs, “California's Implementation of the Affordable Care Act: Implications for Immigrants in the State” and “The Affordable Care Act: Coverage Implications and Issues for Immigrant Families,” detail changes in health insurance policy under the ACA and implications for immigrants (Gelatt, Koball, and Pedroza 2014; Kenney and Huntress 2012).

Nationally and in California, the ACA may affect immigrant families’ access to health insurance and health care through two main channels: (1) expansion of Medicaid eligibility in some states and (2) state insurance marketplaces, in which families can purchase private health insurance, with subsidies for lower-income families. Changes in funding streams for primary care could also affect access to health care for immigrants who form part of the residually uninsured population under the ACA. And funding for outreach could help facilitate immigrant families’ enrollment in new insurance options.

Expanded Medicaid coverage. The ACA gives states the option of expanding Medicaid coverage to any individual (subject to immigrant eligibility restrictions) with a household income at or below 133 percent of the federal poverty level (FPL), a substantially higher income threshold than most states used before the ACA. The federal government funds most of the cost of this expansion. In June 2013, California’s legislature voted to undertake this expansion.

Access to state insurance marketplaces. The ACA also creates state health insurance marketplaces where individuals and families who do not have sufficient employer-provided health insurance can purchase private insurance. These marketplaces are open to lawfully present immigrants and US
citizens, even during the five-year ban, with subsidies based on income level. California was the first state in the country to set up a state health insurance marketplace, called Covered California.

**Funding changes for safety-net care for the uninsured.** The ACA also offers some changes in funding for health insurance and health care that could affect safety-net care for individuals who remain uninsured under the ACA, such as unauthorized immigrants. The ACA mandates increased funding for community health centers and other federally qualified health centers (FQHCs) and FQHC look-alikes, which are a key source of care for the uninsured. The ACA also temporarily increases federal payment rates for primary care provided through Medicaid for 2013 and 2014, increasing revenues to local providers. Additionally, the ACA provides funding streams intended to increase the supply of primary care providers (Hill, Courtot, and Wilkinson 2013). The inflow of new funding streams and an increase in the share of patients with insurance could free up additional funding for the provision of primary care to remaining uninsured individuals, such as unauthorized immigrants. At the same time, as the proportion of patients with insurance rises, the ACA will gradually lower funding for disproportionate share hospital payments to hospitals.

**Concerted outreach efforts.** The ACA requires states using the federally created health insurance marketplace (healthcare.gov) or a federally facilitated marketplace to train Navigators to provide outreach and enrollment assistance to individuals seeking insurance, “in a manner that is culturally and linguistically appropriate to the needs of the population being served.” These services could increase coverage among eligible immigrant populations who may otherwise face information or language barriers in applying.

**Promising Practices and Remaining Challenges for Connecting Immigrant Families to Health Insurance in California**

Our site visit and discussions in California focused on promising practices and challenges to providing health insurance to immigrants. For more on these findings see Gelatt, Koball, and Pedroza (2014). California’s promising practices include the creation of programs to provide health insurance and primary care to immigrants who are not covered by other programs, sustained efforts to provide outreach about available insurance, and efforts to facilitate enrollment among immigrants who speak languages other than English or who may be afraid to apply because of their immigration status. Ongoing challenges include insurance affordability for low-income immigrant families, complexities in
enrollment and eligibility verification, and shortages of primary care providers. Most of these strengths and challenges are not unique to California, but the historical, policy, and demographic context in which they occur differs from that in other states.

**Promising practices.** California has many years of experience serving large numbers of immigrants in its health insurance and health care systems. The state has made great strides in finding ways to translate outreach materials and information about available health insurance programs, and to hire bilingual staff who speak various foreign languages. California has also designed application forms to state that applicants need only provide Social Security numbers for people who are applying for insurance and to explain that parents can apply for their children even when parents are ineligible for coverage.

In recent decades, California has leveraged networks of trained enrollment assistants at nonprofit agencies to conduct outreach and application assistance aimed at increasing enrollment of immigrant and limited English proficient populations in its public health insurance system. California has also used funding streams creatively to cover residents, including immigrants who are not able to access mainstream public insurance systems or who might have difficulty maintaining insurance coverage. The state offers a number of state- and county-funded health insurance programs and primary care systems that are open to residents regardless of immigration status. These programs focus particularly on children, pregnant women, and residents with HIV/AIDS or certain forms of cancer.

**Ongoing challenges.** Despite these strengths, advocates and service providers we met with expressed concern about ongoing barriers to health care access for immigrants. Immigrants are overrepresented in the low-income population, and some concerns remain about whether insurance offered through the state exchanges will be viewed as affordable by immigrant families, even with subsidies. Lawfully present immigrants will be eligible to purchase insurance through Covered California, with their share of the insurance premium cost capped on a sliding scale from 2 percent of family income for those with incomes at or below 133 of FPL to 9.5 percent for those at 400 of percent FPL. Advocates and service providers are concerned that paying nearly 10 percent of family income for health insurance may be difficult for lower-income families, who may choose to allocate income to other necessities instead.

Outreach to and enrollment of California’s diverse immigrant population remains a challenge. Although the ACA provides funding for outreach and enrollment assistance, this funding does not cover assistance provided to families who enroll in Medicaid. Many immigrant families have incomes qualifying them for Medicaid rather than Covered California. These immigrant families may require
more Medicaid enrollment assistance than the average family, and it is unclear whether proper
incentives are in place to encourage enrollment assistants to take on this challenge. Providing
translated materials and in-person assistance to immigrants in their native languages is an ongoing
challenge given the wide variety of languages spoken by immigrants in the state.

Interviewees expressed concern about how the electronic enrollment system used to screen
families’ eligibility for Medicaid and Covered California would operate, and how exactly it would screen
eligibility for immigrants without Social Security numbers, or accommodate applicants who prefer not
to include income information for family members who are unauthorized immigrants. Interviews also
revealed worries that there are not enough primary care physicians who accept Medicaid, particularly
in lower-income rural areas and urban neighborhoods where large numbers of immigrants may live.
These provider shortages could become more severe as increasing numbers of Californians obtain
Medi-Cal coverage and seek health care.

Barriers and Promising Practices in Four States

Our in-depth examination of the ACA's impact on immigrants was limited to California. In order to study
the full range of public benefits available to some categories of immigrants through the US Department
of Health and Human Services, we examined four additional states. Urban Institute researchers
conducted site visits in Maryland, Massachusetts, North Carolina, and Texas to investigate the barriers
that lead to lower rates of health and human services use by immigrant families, as well as potential
strategies for overcoming these barriers.

Methods and Context within the States

Urban Institute researchers visited the states between May and December 2011 and held in-person
and phone discussions with state and local government agencies (including those responsible for
administering Medicaid and CHIP, SNAP, and TANF), community-based organizations (including
immigrant-serving organizations, health care organizations, and faith-based organizations), and
advocates (including directors of grassroots and statewide advocacy organizations, local community
leaders, and immigration legal aid experts). Discussions focused on standard practices, barriers, and
innovative or promising practices influencing immigrants’ access to health and human services. This
process is explained in greater detail in the briefs "Promising Practices for Increasing Immigrants’
The four states of focus were selected to provide variation in (1) the timing of immigrant inflows (new immigrant destination states versus traditional high-immigration states); (2) the size, concentration, and diversity of immigrant populations; (3) immigrants' eligibility for health and human services; (4) immigrants' use of health and human services; and (5) state and local immigration policy and local immigration enforcement activities.

Massachusetts has a large and diverse immigrant population. It has been generous in providing public benefits to immigrants, including state-funded food assistance, public insurance for legal immigrants during the five-year ban, and insurance of last resort for nonqualified and undocumented immigrants.

Texas has a large, mainly Mexican immigrant population and a long history of immigration. The state has relatively restrictive public benefits policies for all residents, including immigrants. For example, Texas does not provide benefits to immigrants during the five-year ban and does not provide TANF or Medicaid to qualified immigrants after the five-year ban, though it does provide Medicaid and CHIP to lawfully present pregnant women and children. The state has widely implemented programs to foster cooperation between local police and federal immigration enforcement.

North Carolina is a new immigrant destination, with a mainly Latino immigrant population. Like Texas, North Carolina is restrictive in its provision of public benefits to immigrants, with the exception of health insurance for lawfully present pregnant women and children. North Carolina has also adopted more state and local immigration enforcement efforts than the other states studied.

Finally, Maryland has a large and diverse immigrant population and is generous in its provision of benefits to immigrants. Maryland has focused heavily on immigrant access to interpretation and translation services.

**Barriers to Accessing Health and Human Services**

Discussions in the four states revealed a number of barriers limiting immigrants' access to public benefits, beyond eligibility policies. These barriers fall into five main categories: (1) application, documentation, and verification challenges; (2) administrative errors and burdens; (3) language, literacy, and cultural barriers; (4) logistical and information barriers; and (5) fears about applying for
programs. We briefly outline these barriers below; greater detail is available in the brief by Perreira and colleagues (2012).

**Application, documentation, and verification challenges.** A number of administrative and documentation challenges make it hard for immigrant families to successfully enroll in available programs. Respondents reported that eligibility policies for immigrants change rapidly, challenging administrators to keep their knowledge up to date. Spaces for Social Security numbers or immigration status on application forms also reportedly discourage participation. Immigrants who are paid in cash and do not have regular pay stubs or other proof of income sometimes struggle to document income eligibility for programs. Many areas allow letters from employers, but employers may not wish to verify that they employ immigrants they suspect lack authorization to work in the United States. Immigrants whose names are not on their leases sometimes have trouble proving their residence in a jurisdiction, and parents are not always able to obtain children’s birth certificates because they are asked to provide a government identification card to do so. Given these barriers, immigrant families may have difficulty maintaining benefits when programs require frequent recertification (every 6 or 12 months) or when families move across county lines and must reapply for benefits.

**Administrative burdens and errors.** The complexity of enrolling immigrants in benefits often leads to strain among caseworkers conducting enrollment and sometimes leads to administrative errors. Staff reported needing to become familiar with a wide variety of documents proving various immigration statuses, without sufficient training. Computer systems are often not set up to accommodate two last names (common among Latin American immigrants), and caseworkers dealt with this complexity in different ways, leading to mismatched administrative records. Finally, personnel at public agencies and CBOs said that budget cuts and growing immigrant caseloads had reduced their ability to provide adequate outreach and assistance to immigrants applying for benefits.

**Language, literacy, and cultural barriers.** While all agencies we interviewed make efforts to translate written materials, their web sites are often built primarily for English readers, and front desk staff are not always able to accommodate all clients’ languages. Health and human services offices reported that they are not always able to find and hire as many bilingual and bicultural staff members as desired, so often rely on friends, family, and even children of applicants to translate. Others rely on translation phone lines, which do not allow for privacy and are seen as cumbersome. Programs do not always adequately accommodate applicants with limited literacy skills. Finally, cultural factors such as beliefs about gender roles, attitudes toward government, and definitions of family can also deter enrollment in available benefits.
Logistical and information barriers. Immigrant families face many logistical barriers that may prevent them from applying for benefits. Immigrants sometimes find it difficult to access transportation to offices, which is a significant barrier when programs require in-person application. Not all immigrants can afford a car, while others do not know how to drive or are not eligible for driver’s licenses. In some areas, public transportation is not sufficient to connect immigrants to public benefits offices. In addition to transportation barriers, immigrants’ work schedules are often incompatible with the hours when public offices are open for service. Informational barriers also present a substantial challenge: for example, benefits information is often communicated via word of mouth, so immigrants whose networks are not linked to those with knowledge of and experience with public benefits often do not receive adequate information about the benefits available to them. This barrier is particularly common among immigrants in rural areas or areas with few immigrant-serving CBOs.

Immigration-related fears. According to our visits and discussions, fears of detection and deportation strongly shape immigrant access to benefits, particularly given increasing immigration enforcement in the past several years. Unauthorized immigrants or legal immigrants with unauthorized household members often fear that applying for benefits will lead to detection by immigration enforcement authorities. Immigrants are often misinformed about the implications of accessing benefits on their ability to apply for legal status or US citizenship in the future. Increased cooperation between local law enforcement and federal immigration enforcement authorities in states such as North Carolina and Texas has reportedly led immigrants to fear interactions with government officials more than they did previously.

Promising Practices for Increasing Immigrants’ Access to Services

After collecting information about the barriers that immigrant families face in accessing health and human services benefits and services, Urban Institute researchers investigated promising practices that have helped agencies and families overcome such barriers. The brief by Crosnoe and colleagues (2012) lays out these findings in greater detail.

Streamlining application and eligibility procedures. Streamlining applications for services can facilitate the application process for immigrant families, as for other families, with some caveats. Some states, such as North Carolina, are working to streamline applications by using a single common application for multiple benefits programs. A common-application model could be particularly beneficial for immigrant families, since transportation and work schedules can make multiple in-person applications burdensome. Conversely, since eligibility can vary by program, streamlined applications
may present barriers for mixed-status families in which some family members are eligible for certain benefits and others are not. Systems that allow ineligible family members to opt out of applications for certain benefits could help adapt streamlined applications to meet the needs of immigrant families.

**Overcoming cultural issues.** CBOs can help immigrant families overcome cultural barriers to accessing services. Agencies and CBOs can work together to provide culturally appropriate outreach to immigrants in locations frequented by immigrant families. Religious organizations can also provide culturally sensitive outreach. And agencies can reach out to immigrants through ethnic media and local businesses, by placing ads on foreign-language radio and television stations, and conducting outreach in grocery stores. Embedding messages in *telenovelas* or other television programs popular among immigrant groups could also be a clever approach for delivering important information to immigrants.

**Overcoming language, literacy, transportation, and logistical issues.** Most agencies translate materials into Spanish, contract with translation services, and use a telephone language line for translation. Massachusetts has done more than the other states to translate materials into a wide variety of languages, and to hire bilingual staff to cover many languages. Programs across the states increasingly employ symbols and pictures in materials to facilitate use by families with limited literacy. Child care and transportation barriers remain difficult to overcome, but refugee-serving agencies provide a useful example for addressing these challenges, with programming focused on teaching families to use public transportation; apply for driver’s licenses; and learn English, computer skills, and financial literacy.

**Integrating services for immigrant families.** In addition to integrating application forms and processes, some health and human services agencies are working to provide multiple services in the same location. For example, multiservice centers in Houston colocate Women, Infants, and Children services, food pantries, health clinics, and application centers for other benefits. CBOs tend to cluster near these service centers as well. Maryland similarly provides clusters of service centers, using funding from the Office of Refugee Resettlement. And public schools are promising sites for conducting outreach around available services. For example, the Austin Independent School District screens families for eligibility for federal and county benefits and collects information on students’ insurance status in order to map out pockets of high uninsurance rates in the city and guide outreach efforts. Maryland shares SNAP information with families of children who receive free or reduced-price lunches.

**Addressing mixed-status families’ application challenges.** Some agencies have created forms and policies that facilitate benefit applications for mixed-status families. For example, Massachusetts’s application forms provide an option for individual family members to opt out of applications for certain
benefits, and Maryland’s application materials clearly state that Social Security numbers are not required for family members who are not applying for benefits.

**Collaboration between agencies and CBOs.** The role of community-based organizations in connecting immigrant families to public benefits was the most frequently reported promising practice. We provide more information on the importance of CBOs in the next section of this report. Cooperation between governments and CBOs can take many forms. In Massachusetts, for example, agency administrators and staff from immigrant-serving advocacy organizations meet monthly to share policy changes and community concerns. State agencies in Texas and Massachusetts contract with CBOs to provide assistance filling out and submitting applications, and CBOs often conduct this work even without formal contracts. In North Carolina, some agencies have staff located within CBO offices where they can more easily reach the population they are seeking to enroll. Finally, CBOs can facilitate applications by helping to secure income verification from employers, or by issuing a form of membership and identification that families can use on some application forms.

**The Role of CBOs in Facilitating Access to Benefits**

The briefs summarized above touched on the role that CBOs can play in conducting culturally sensitive outreach and enrollment assistance as well as facilitating families’ ability to apply for available benefits. An additional brief explores in depth the roles that CBOs can play in improving immigrants’ access to benefits (Yoshikawa et al. 2014).

**Building relationships with immigrant families.** Research has shown that information presented to low-income parents has more impact when it comes from a trusted mentor rather than a service provider (Capps and Fortuny 2006; Chaudry and Fortuny 2010; Yoshikawa et al. 2011). Many immigrant-serving CBOs develop strong relationships with immigrants by using a client-centered model, investigating the full range of families’ needs, and accompanying them when they apply for services. The *promotora* model has been adopted widely, particularly for health care outreach. Under this model, public agencies and CBOs train community members to hold meetings in immigrants’ gathering places and disseminate information about health conditions and available health insurance. Families develop trusting, ongoing relationships with *promotoras*, increasing their comfort with the application process.

**Targeting homes and community settings.** CBOs can spread the word about available programs and help with enrollment processes by visiting families in locations they frequent. For example, in North...
Carolina, CBOs hold meetings with farmworkers in the fields and in their homes. Other sites for such outreach can include schools, workplaces, and even grocery stores. Some government agencies embed workers in CBOs. Other agencies train nonprofit staff to conduct enrollment. For example, the Texas Health and Human Services Commission trains food bank workers to enroll families in SNAP. Connecting to faith-based community organizations can also be a particularly fruitful way for agencies to reach immigrant families.

**Building networks across nonprofit, private, and public sectors.** Networks of CBOs, government agencies, and private businesses can help reduce redundancies in outreach and enrollment efforts and ensure wide coverage. Umbrella organizations uniting multiple CBOs can provide centralized training and a common information hotline. Collaboration between advocacy organizations, nonprofit service providers, agencies, and businesses can bring together diverse knowledge and experience to inform and improve the provision of services. The Massachusetts Department of Transitional Assistance, for example, has an advisory board composed of advocates, CBO representatives, community members, and state government workers. The advisory board provides a forum for facilitating cooperative efforts, informing groups of policy changes, and sharing knowledge of issues that arise in immigrant communities.

**Conclusions**

Eligibility policies limit immigrants’ access to some parts of the safety net supporting low-income and poor families in the United States. The ACA opens public health insurance and affordable private health insurance to some immigrant families who were previously uninsured, but not all. And even immigrants who are eligible for safety-net programs face a number of administrative, logistical, and cultural barriers to accessing benefits.

Our research found that complicated eligibility criteria combined with existing data systems and eligibility screening forms and processes made enrollment difficult for both agency staff and immigrant families. Further, logistical barriers—such as the difficulty and expense of providing in-person translation in all languages, and immigrants’ struggles to satisfy in-person application requirements in light of work schedules and limited transportation—prevented other families from applying for benefits. Immigration enforcement policies combined with misperceptions among immigrant families can also create a climate of fear, in which immigrants are unwilling to provide the information needed to access
benefits. Therefore, it is not surprising that eligible low-income immigrant families have substantially lower receipt rates for SNAP, TANF, Medicaid, and CHIP benefits than other low-income families.

Our research in California, Maryland, Massachusetts, North Carolina, and Texas uncovered a number of promising practices that can help bridge the gap between available public supports and immigrants’ needs. The most commonly mentioned promising practice for government agencies is collaboration with community-based organizations, particularly those already serving immigrants. Community-based organizations can provide linguistically and culturally appropriate outreach, build trust between immigrant communities and programs, bring enrollment services to places immigrants already visit, overcome cultural barriers, and communicate important program and eligibility information.

In addition to working with CBOs, agencies can facilitate access to services and benefits by increasing and improving translation of written materials, using simple language for those with limited literacy, and using interpreter services or interpretation phone lines when bilingual staff cannot be hired. Agencies can also help immigrant families enroll in benefits by moving enrollment procedures to convenient locations or providing transportation, having open hours outside the normal workday, and providing child care.

Agencies can also address a common application barrier by simplifying documentation requirements for eligibility screening and enrollment. By also ensuring that enrollment forms clearly state what information is required for all members of the household, and what information is required only for those who would be receiving benefits, agencies can facilitate enrollment among mixed-status families while helping to overcome immigrants’ fears about immigration enforcement. Common enrollment forms for multiple benefits programs and one-stop service provision locations can also facilitate benefit access among families with limited transportation and difficult work schedules.
Appendix A. Definitions

**Foreign-born:** Someone born outside the United States and its territories, except those born abroad to US-citizen parents. The foreign-born include those who have obtained US citizenship through naturalization and people in different immigration statuses. People born in the United States, Puerto Rico, and other territories, or born abroad to US-citizen parents, are native-born.

**Immigrant:** A foreign-born person who is not a citizen of the United States as defined by the Immigration and Nationality Act, Section 101 and the following (similar to the statutory term "alien"). This definition of immigrant is narrower than some common definitions that treat any foreign-born person as an immigrant, including those who have become naturalized citizens. Since a central focus of this study is on immigrant eligibility, and citizenship is a key factor in determining eligibility for benefit programs, this brief adheres to the legal definition of immigrant.

**Lawful permanent residents (LPRs):** People lawfully admitted to live permanently in the United States by either qualifying for immigrant visas abroad or adjusting to permanent resident status in the United States. Many but not all LPRs are sponsored (i.e., brought to the United States) by close family members or employers.

**Naturalized citizens:** LPRs who have become US citizens through naturalization. Typically, LPRs must be in the United States for five or more years to qualify for naturalization. Immigrants who marry citizens can qualify in three years, and some smaller categories can qualify sooner. LPRs generally must take a citizenship test—in English—and pass background checks before qualifying to naturalize.

**Refugees and asylees:** People granted legal status because of persecution or a well-founded fear of persecution in their home countries. Refugee status is granted before entry to the United States. Asylees usually arrive in the United States without authorization (or overstay a valid visa), claim asylum, and are granted asylee status once their asylum applications are approved. Refugees and asylees are eligible to apply for permanent residency after one year.

**Undocumented or unauthorized immigrants:** Immigrants who are not LPRs, refugees, or asylees and have not otherwise been granted permission under specific authorized temporary statuses for lawful residence and work.

**Lawfully present immigrants:** Lawfully present immigrants include LPRs, refugees, and asylees, as well as other foreign-born persons who are permitted to remain in the United States either temporarily or indefinitely but are not LPRs. Some lawfully present immigrants have entered for a temporary period
for work, as students, or because of political disruption or natural disasters in their home countries. Some may seek to adjust their status and may have a status that allows them to remain in the country but does not grant the same rights as LPR status. The term “lawfully present” is used for applying for Title II Social Security benefits and is defined in the Department of Homeland Security regulations at 8 CFR 103.12(a). The same definition is also used by the US Department of Agriculture for determining eligibility for food stamp benefits. In 2010, the Centers for Medicare and Medicaid issued guidance to states that further defined “lawfully present” for determining eligibility for Medicaid and CHIP benefits under the Children’s Health Insurance Program Reauthorization Act of 2009.

**Qualified immigrants:** The following foreign-born people are considered eligible for federal benefits:

- LPRs
- refugees
- asylees
- people paroled into the United States for at least one year
- people granted withholding of deportation or removal
- people granted conditional entry (before April 1, 1980)
- battered spouses and children (with a pending or approved spousal visa or a self-petition for relief under the Violence Against Women Act)
- Cuban and Haitian entrants (nationals of Cuba and Haiti who were paroled into the United States, applied for asylum, or are in exclusion or deportation proceedings without a final order)
- victims of severe human trafficking (since 2000, victims of trafficking and their derivative beneficiaries [e.g., children] are eligible for federal benefits to the same extent as refugees and asylees)

**Nonqualified immigrants:** Immigrants who do not fall into qualified immigrant groups, including immigrants formerly considered permanently residing under color of law, immigrants with temporary protected status, asylum applicants, other lawfully present immigrants (such as students and tourists), and unauthorized immigrants.

**Five-year ban:** Under TANF, SNAP, Medicaid, and CHIP, post-enactment qualified immigrants, with important exemptions, are generally banned from receiving federal means-tested benefits during their first five years in the United States.
Appendix B. Methods

The briefs making up the Immigrant Access to Health and Human Services project relied on a variety of methods to compile information about federal and state public benefits policies, investigate access barriers and promising practices for overcoming those barriers, and detail rates of immigrant families’ access to public benefits. Here we briefly summarize the methods employed in this project. More detail can be found in the issue briefs making up this project, available at http://aspe.hhs.gov/hsp/11/ImmigrantAccess/index.shtml.

Describing federal and state policies: Information on federal and state public benefits policies for immigrants was collected from the National Immigration Law Center’s summary of eligibility provisions for SNAP, TANF, Medicaid, and CHIP by state; the Urban Institute’s Welfare Rules Database, which details state rules for cash assistance under TANF; the Centers for Medicare and Medicaid Services; and the Urban Institute’s TRIM3 data on state eligibility rules for SNAP, TANF, Medicaid, and CHIP. Additional information on California’s policies under the ACA was derived from publicly available information and conversations with California program administrators and health policy experts.

Selection of states: To investigate the barriers that lead to lower rates of health and human services use among immigrant families and potential strategies for overcoming these barriers, the Urban Institute conducted site visits in Maryland, Massachusetts, North Carolina, and Texas. These four states were selected to provide variation in (1) the timing of immigrant inflows (new immigrant destination states versus traditional states of high immigration); (2) the size, concentration, and diversity of immigrant populations; (3) immigrants’ eligibility for health and human services; (4) immigrants’ use of health and human services; and (5) immigration policy and local immigration enforcement activities.

In addition, the Urban Institute conducted a site visit in California to explore the state’s changes to health policy under the ACA and the ways in which the implementation of the ACA might affect immigrants. California was selected for its large immigrant population, and because it had taken action to begin implementing the ACA.

Site visits: Researchers visited Maryland, Massachusetts, North Carolina, and Texas between May and December 2011, and California in February 2013, conducting in-person and phone conversations with state and local government agencies (including those responsible for administering SNAP, TANF, Medicaid, and CHIP), community-based organizations (including immigrant-serving organizations, health care organizations, and community and faith-based organizations), and advocates (including directors of grassroots and statewide advocacy organizations, local community leaders, and
immigration legal aid experts). Questions focused on standard practices, barriers, and innovative or promising practices influencing immigrants’ access to health and human services.

**Analysis of American Community Survey data:** Rates of immigrant families' use of SNAP, TANF, Medicaid, and CHIP were determined by tabulating data from the 2008 and 2009 American Community Survey, accessed through the University of Minnesota's Integrated Public Use Microdata Series (Ruggles et al. 2010).
Notes


2. The term “immigrant” includes individuals born abroad who have obtained US citizenship through the naturalization process.

3. States are required to provide TANF, SNAP, Medicaid, and CHIP to refugees and asylees, LPRS with 40 quarters of qualifying work, and military members and veterans, even during their first five years of qualified status.

4. "Lawfully present" and “qualified” immigrants are two different categories, including slightly different groups of immigrants. These categories are both defined in appendix A.

5. The eligibility threshold is generally stated as 133 percent, but is effectively 138 percent since 5 percent of income is disregarded when determining eligibility.

6. Before the ACA, the median income eligibility threshold for Medicaid was 64 percent of FPL for working parents and 37 percent of FPL for nonworking parents; more than half of states did not offer Medicaid to nondisabled childless adults (Kenney and Huntress 2012).

7. The federal government will cover 100 percent of the cost of Medicaid for the newly eligible population for 2014–17, 95 percent in 2017, 94 percent in 2018, 93 percent in 2019, and 90 percent in 2020 and thereafter.

8. Lawfully present immigrants and US citizens with family incomes up to 400 percent of FPL are eligible for premium tax credits, and those with incomes below 250 percent of FPL are also eligible for cost-sharing subsidies to help pay for deductibles and copayments.

References


About the Editors

**Julia Gelatt** is a research associate in the Center on Labor, Human Services, and Population at the Urban Institute. In addition to analyzing the Affordable Care Act’s implications for immigrants, Gelatt’s work on immigration includes a review of promising practices for connecting immigrant families to prekindergarten, a description of the limited English proficient population in Washington, DC, and research on the implications of parents’ and children’s immigration status for children’s health and well-being. Her work uses mixed methods, including secondary data analysis, original survey development, administrative data analysis, and qualitative interviews.

**Heather Koball** is a senior fellow in the Center on Labor, Human Services, and Population, where her areas of expertise include immigration and at-risk youth. Koball has directed multiple projects on issues faced by children of immigrants, including a study of the well-being of children whose families have been affected by immigration enforcement, access to public benefits among immigrant families, the implications of the Affordable Care Act for immigrants’ health care, and immigrant integration in new destination areas.