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State Health Insurance and Access for Foreign Born

Brief Communication

State Specific Medicaid/CHIP Eligibility Criteria and Impact on Healthcare Access for Foreign- born Children Living in the United States

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List of Abbreviations:
CHIP= Children's Health Insurance Program
NSCH= National Survey of Children's Health
D.C. = District of Columbia
SPSS= Statistical Package for the Social Sciences
FPL= Federal Poverty Line

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Abstract: **Introduction**. Foreign-born children are subject to discrepant state policies in determining eligibility for Medicaid/Children's Health Insurance Program (CHIP) coverage. The objective of this study was to determine the effect of these policies on health care access. **Methods**. Data from the National Survey of Children's Health (NSCH) were used to assess associations between health care access outcomes and three categories of state health insurance eligibility: restrictive (only U.S. citizens plus immigrants who "qualified" after five-year waiting period), semi-restrictive (same as restrictive except no waiting period), and inclusive (all children). **Results**. When compared with restrictive states, foreign-born children in inclusive states were significantly more likely to have current insurance, consistent coverage, recent preventive exams, and fewer problems paying medical bills. **Discussion**. Extending health care eligibility to all children, regardless of immigration status, improves health care coverage and access for foreign-born children. Expansion of eligibility criteria in all states is necessary to reduce health disparities in the immigrant population.

Key words: Health care access, health policy, uninsured, immigrant health, Medicaid, CHIP.

Nativity is an important social determinant of health that can affect children's access to health care.[1] Non-citizen children are more likely than citizen children to lack insurance coverage.[1,2] In 2019, 21% of lawfully residing and 35% of undocumented immigrant children were uninsured, compared with an uninsured rate of 5% in citizen children with U.S.-born parents.[2] It is known that uninsured children are less likely than insured children to see a physician or receive necessary medical care, and the additional socioeconomic, linguistic, and cultural barriers immigrant families face have been shown to create a cumulative disadvantage that directly affects the health of their children.[3–6] Despite efforts to address these barriers, there remains a paucity of data focused specifically on foreign-born children (excluding U.S.-born children with foreign-born parents) and the impact of states' children's health insurance policies.[5]

Eligibility criteria for Medicaid/Children's Health Insurance Program (CHIP) are determined by each state, leading to wide variability. In 1996, the year CHIP became law, the federal government, through the Personal Responsibility and Work Opportunity Act, barred unauthorized immigrants from accessing many federal benefits and mandated that Medicaid/CHIP eligibility could only be extended to "qualified residents" after a five-year waiting period. This also applied to Medicare and insurance offered through marketplaces by the Affordable Care Act.[7,8] Nearly all the children subject to this waiting period are lawful permanent residents (i.e., green card holders). States may opt to use state funding to provide coverage and effectively remove this waiting period, and many have done so. Others have elected to change their eligibility criteria to include all low-income children, regardless of immigration status or time in the U.S.[2] State-determined policies can thus be divided into three general categories: 1) 19 states require the five-year waiting period and offer very limited eligibility to other non-U.S. citizen children (restrictive); 2) 25 states have waived the five-year waiting period but still have very limited eligibility for other non-U.S. citizen children (semi-restrictive);

and 3) six states plus the District of Columbia (D.C.) have waived the waiting period and extended Medicaid/CHIP eligibility to all low-income children, regardless of their immigration status (inclusive) (Figure 1).

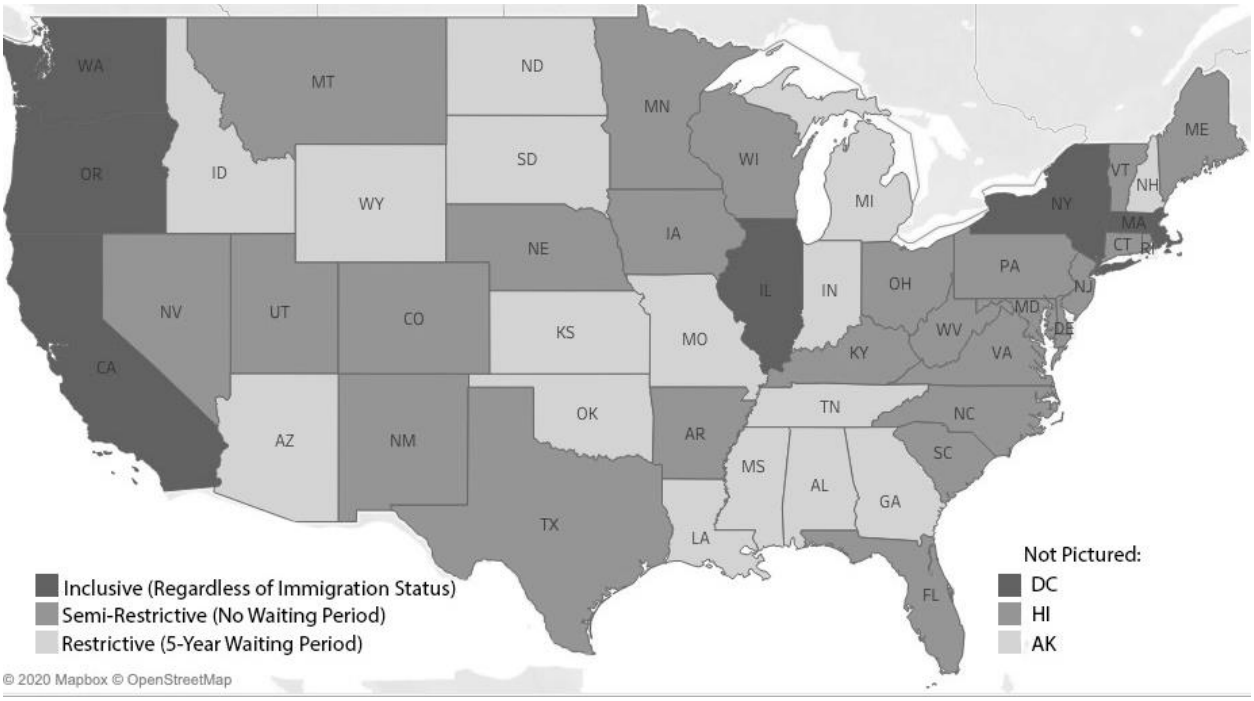

Figure 1. Descriptive graph of state Medicaid/CHIP eligibility for foreign-born children.

This study examined the relationship between Medicaid/CHIP eligibility criteria and insurance status of foreign-born children, as well as how eligibility affects other important indicators of health care access.

Methods

This was a cross-sectional study looking at foreign-born children in the 2016-2017 National Survey of Children's Health (NSCH). The NSCH is conducted by the U.S. Department of Health and Human Services, Health Resources and Services Adminstration's Maternal and Child Health Bureau. It is intended to be a cross-sectional survey of child health and well-being, inquiring

about physical and mental health, access and quality of health care, and questions about family, school, and social situations. The 2016-2017 survey was a redesign and combination of the National Survey of Children's Health (NSCH) and the National Survey of Children with Special Health Care Needs (NSC-SHCN). Prior surveys had been conducted via telephone, but this survey used an address-based sampling approach as well as paper and web-based questionnaires. A total of 71,811 surveys were completed in 2016-2017. Survey results were weighted to create a representative sample of national and state-level data on the physical and emotional health of American children 0-17 years old. Further details can be found at www.childhealthdata.org.[9,10]

Comparisons were made across the three state-based insurance categories and the following outcomes derived from NSCH Indicator Questions: current health insurance coverage, consistency of coverage, usual source of sick care, problem paying medical bills, preventive exams, and forgone care. All foreign-born children in the dataset were included. There were no discrete exclusion criteria.

Demographic and socioeconomic factors were compared across the three types of state-based health insurance using non-parametric testing. For categorical variables, the Pearson chi-square test was used. For continuous variables, the Kruskal-Wallis test was used. For any comparison that had a p-value<.05, post hoc analyses using adjusted (Bonferroni) standardized residuals or pair-wise comparisons were used to identify significant cell values. Any demographic or socioeconomic factor with a p-value ≤.20 was included in subsequent models for adjustment. Health access outcomes were then compared across the three state categories, and all comparisons with a p-value ≤.20 were considered for further binary logistic regression modeling. These models were adjusted using the selected demographic and socioeconomic factors that met the above criteria.

All analyses were performed using the Statistical Package for the Social Sciences (SPSS), version 26 (IBM Corp., Armonk, NY). This study was granted exemption by the Baylor College of Medicine Institutional Review Board.

Results

There were 2,308 foreign-born children in the study. Of these, 611 (26.5%) resided in restrictive states, 1,304 (56.5%) were in semi-restrictive states, and 393 (17.0%) were in inclusive states (plus D.C.). Based on the descriptive comparison analysis, the following factors were selected for model adjustment: age, ethnicity/race, parental nativity, primary language, and poverty status (federal poverty line or FPL) (Table 1). Before adjusting for these factors, inclusive states were found to have higher rates of current health insurance (p-value = .01), consistent coverage (p-value = .02), no issue with medical expenses (p-value = .01), and greater rates of having one or more preventive exam in past year (p<.02). Having a usual source for sick care and forgoing care were not found to be significantly different among types of states (Table 2).

Table 1.
DEMOGRAPHIC AND SOCIOECONOMIC STATUS COMPARISONS OF FOREIGN-BORN CHILDREN BY ACCESS TO STATE-BASED HEALTH INSURANCE (N = 2308)

	Restrictive[a] N = 611 (26.5%) N (%) or Median (IQR)	**Semi-Restrictive[b] N = 1304 (56.5%) N (%) or Median (IQR)**	**Inclusive[c] N = 393 (17.0%) N (%) or Median (IQR)**	**p-value[d]**
Age (continuous)	12.0 (7.0, 15.0)	12.0 (8.0, 15.0)	11.0 (7.0, 15.0)	.05
Gender				
Male	307 (50.2)	620 (47.5)	179 (45.5)	.32
Female	304 (49.8)	684 (52.5)	214 (54.5)	
Ethnicity/Race				
Hispanic	107 (17.5)[e]	305 (23.4)[e]	75 (19.1)	
White	188 (30.8)[e]	328 (25.2)	92 (23.4)	.02
African-American	50 (8.2)	98 (7.5)	34 (8.7)	
Asian	212 (34.7)	480 (36.8)	159 (40.5)	

Other	54 (8.8)	93 (7.1)	33 (8.4)	
Parental nativity				
All parents USA	216 (36.8)	429 (34.6)	109 (28.8)[e]	.04
Any parent outside USA	371 (63.2)	812 (65.4)	269 (71.2)[e]	
Primary language				
English	410 (67.8)[e]	811 (62.9)	225 (58.0)[e]	.01
Other than English	195 (32.2)[e]	479 (37.1)	163 (42.0)[e]	
Public assistance				
Did not receive	458 (75.5)	929 (72.6)	276 (71.0)	.50
Received 1-2 types	127 (20.9)	308 (24.1)	98 (25.2)	
Received 3-4 types	22 (3.6)	43 (3.4)	15 (3.9)	
Highest adult education				
< high school	29 (4.8)	60 (4.7)	18 (4.7)	.31
High school/GED	76 (12.7)	130 (10.1)	40 (10.4)	
Some college/technical	79 (13.2)	175 (13.7)	38 (9.8)	
≥ College degree	415 (69.3)	917 (71.5)	290 (75.1)	
Poverty Status				
0-99% FPL	96 (15.7)	201 (15.4)	67 (17.0)	.03
100-199% FPL	112 (18.3)	217 (16.6)	63 (16.0)	
200-399% FPL	188 (30.8)[e]	331 (25.4)	92 (23.4)	
≥400% FPL	215 (35.2)[e]	555 (42.6)	171 (43.5)	
Number in household				
1 or 2	35 (5.9)	83 (6.7)	22 (5.9)	.47
3	203 (34.5)	447 (36.0)	133 (35.9)	
4	214 (36.3)	461 (37.1)	140 (37.8)	
5	80 (13.6)	159 (12.8)	55 (14.9)	
≥6	57 (9.7)	91 (7.3)	20 (5.4)	
Employment status				
Work 50 wks/yr	552 (92.0)	1145 (90.0)	341 (89.0)	.25
Do not work 50 wks/yr	48 (8.0)	127 (10.0)	42 (11.0)	
Mother health status				
BOTH physical/mental	397 (70.6)	842 (71.8)	257 (71.2)	.88
ONE physical/mental	165 (29.4)	331 (28.2)	104 (28.8)	
Father health status				
BOTH physical/mental	372 (72.1)	772 (72.1)	230 (72.6)	.99
ONE physical/mental	144 (27.9)	298 (27.9)	87 (27.4)	

Notes

[a] Coverage after 5 years of lawful residence (federal mandate).
[b] Coverage without 5 year wait period for qualified immigrants.
[c] Coverage regardless of immigration status or time living in U.S. (inclusive).
[d] Pearson Chi-Square p-value across all three groups.
[e] Significantly adjusted (Bonferroni) standardized residuals.

FPL = Federal Poverty Level
GED = General Educational Development
IQR = Interquartile Range

Table 2.
COMPARISONS BETWEEN STATE-BASED INSURANCE AND HEALTHCARE ACCESS OUTCOMES

	Restrictive[a] N = 611 (26.5%) N (%)	**Semi-Restrictive[b] N = 1304 (56.5%) N (%)**	**Inclusive[c] N = 393 (17.0%) N (%)**	**p-value[d]**
Usual source for sick care				
Yes	444 (74.0)	948 (73.8)	294 (75.2)	.85
No	156 (26.0)	337 (26.2)	97 (24.8)	
Current health insurance				
Yes	547 (90.0)	1182 (91.2)	371 (95.1)[f]	.01
No	61 (10.0)	114 (8.8)	19 (4.9)f	
Consistency of coverage[e]				
Continuous all year	532 (87.9)	1145 (88.7)	364 (93.1)[f]	.02
Gap in coverage	73 (12.1)	146 (11.3)	27 (6.9)[f]	
Problem paying medical bills				
No/No expenses	544 (89.8)	1147 (89.5)	371 (94.9)[f]	.01
Yes	62 (10.2)	134 (10.5)	20 (5.1)[f]	
Preventive exam (w/in 1 year)				
1 or more visits	448 (73.9)[f]	1019 (78.9)	316 (80.8)	.02
No visits	158 (26.1)[f]	272 (21.1)	75 (19.2)	
Forgone care				
Needed/Did not receive	20 (3.3)	46 (3.5)	18 (4.6)	.54
Received care/Did not need	588 (96.7)	1251 (96.5)	375 (95.4)	

Notes
[a] Coverage after 5 years of lawful residence (federal mandate)
[b] Coverage without 5-year wait period for lawful resident
[c] Coverage regardless of immigration status or time in US
[d] Pearson Chi-Square p-value across all three groups.
[e] Multi-variable combination: current insurance + gap in insurance.
[f] Significantly adjusted (Bonferroni) standardized residuals.

IQR = Interquartile Range

After controlling for demographic and socioeconomic differences found between groups, statistically significant differences between inclusive states and restrictive states persisted. Children in inclusive states had an increased odds of being currently insured [aOR = 2.39 (CI 1.34 – 4.27); p-value = .003], having consistent coverage [aOR = 1.97 (CI 1.19 – 3.25); p-value = .01], and receiving preventive exams [aOR = 1.68 (CI 1.20 – 2.35); p-value = .002].

The families of children in inclusive states were also less likely to have problems paying medical bills [aOR = 0.52 (CI 0.30-0.90); p-value = .02] (Table 3). When comparing semi-restrictive with restrictive states, the only statistically significant difference was that foreign-born children in semi-restrictive states had an increased chance of having received at least one preventive exam within the past year [aOR = 1.46 (95% CI 1.15 – 1.87); p-value = .002] (Table 3).

Table 3.
ADJUSTED ASSOCIATIONS OF HEALTH CARE ACCESS TO STATE-BASED HEALTH CARE COVERAGE

Outcome	State-based insurance/confounders	aOR[a]	95% CI	p-value
Currently Insured (N=2170) No (ref) Yes	Insurance Coverage Restrictive Semi-Restrictive[b] Inclusive[c]	 Ref 1.21 2.39	 -- 0.84 – 1.74 1.34 – 4.27	 -- .30 .003
Consistency of coverage[d] (N=2162) Gap in coverage (ref) Continuous all year	Insurance Coverage Restrictive Semi-Restrictive[b] Inclusive[c]	 Ref 1.10 1.97	 -- 0.79 – 1.54 1.19 – 3.25	 -- .57 .01
Problem paying medical bills (N=2152) No/No expenses (ref) Yes	Insurance Coverage Restrictive Semi-Restrictive[b] Inclusive[c]	 Ref 1.12 0.52	 -- 0.80 – 1.56 0.30 – 0.90	 -- .52 .02
Preventive exam (w/in 1 year) (N=2165) No visits (ref) 1 or more visits	Insurance Coverage Restrictive Semi-Restrictive[b] Inclusive[c]	 Ref 1.46 1.68	 -- 1.15 – 1.87 1.20 – 2.35	 -- .002 .002

Notes

[a] Adjusted for age, ethnicity/race, parental nativity, primary language and poverty status (FPL).
[b] The aOR, 95% CI and p-value is for the adjusted comparison of "semi-restrictive" vs. "restrictive".
[c] The aOR, 95% CI and p-value is for the adjusted comparison of "inclusive" vs. "restrictive".
[d] Multi-variable combination: current insurance + gap in insurance.

aOR = Adjusted Odds Ratio
CI = Confidence Interval
FPL = Federal Poverty Level

Ref = Reference Category

Discussion

Foreign-born children are subject to significant variation in health coverage in the U.S. due to factors at both the federal and state levels. This study sought to inform policy and advocacy by evaluating health indicators for children in states with different levels of Medicaid/CHIP coverage. Per our analysis, inclusive eligibility criteria are correlated with important health care access outcomes of foreign-born children. Specifically, foreign-born children in inclusive states were more likely to be insured, have consistent coverage, experience fewer problems paying medical bills, and receive preventive exams.

Improving health coverage matters in the lives of children and has multiple positive downstream effects, including some that extend beyond health.[11] For example, health coverage has been shown to reduce avoidable hospitalizations and decrease child mortality while also reducing high school drop-out rates and increasing college enrollment and completion rates.[11–14] This translates into improved health into adulthood, academic success, and economic gains.[15] This study found that foreign-born children residing in inclusive states had significantly higher odds of having both health coverage at the time they were surveyed as well as more consistent coverage. There are many reasons that coverage and consistent coverage vary across states. First, the variability in state policies in the setting of restrictive federal laws creates dramatic differences among immigrant families in accessing health care coverage. As previously discussed, a small minority of states provide coverage to all children, regardless of immigration status or time in the U.S. Most states have significant limitations on health coverage eligibility (Figure 1). The findings in this study suggest that in those states that offer more inclusive coverage, families are choosing to sign up, whereas those in restrictive states are unable to do so. In addition, those in inclusive states are not only signing up, but they are choosing to stay

enrolled, suggesting that families have both the ability and the desire to stay enrolled over time. With most states opting for more restrictive eligibility, these findings are consistent with other studies that have found that across the U.S., immigrants have lower rates of health insurance, health care utilization, and health expeditures.[8,16] Fortunately, the list of states providing coverage to all children, regardless of immigration status, is growing.[2]

In addition to basic eligibility requirements, there are logistic or other barriers that affect health care coverage and consistency of coverage for foreign-born children. For example, there are complex and discrepant state policies and procedures that affect Medicaid/CHIP enrollment and renewal. States that require random income checks for eligibility, have frequent renewal requirements, or are generally unwelcoming to immigrants create barriers to consistent coverage for many families.[18] The nationwide requirement to reapply for Medicaid/CHIP when moving to a new state also adds an enormous barrier to some children maintaining consistent health coverage.[3] Prior studies have found that, nationally, only three-quarters of low-income children who remain eligible for Medicaid/CHIP stay enrolled in the program.[11] In addition to decreasing these logistic barriers to obtaining health insurance, inclusive states may have other attributes that lead to consistent coverage, such as inculcating trust in the immigrant community through the provision of language services and a more inclusive public rhetoric. Studies have demonstrated that anti-immigrant policies and/or rhetoric affect families' willingness to access public benefits, even families with citizen children and those with non-citizen children who are still eligible for certain programs.[3,18–21] Ultimately, our results demonstrating differences in health care coverage for foreign-born children is consistent with other literature that has demonstrated insurance coverage discrepancies between individuals based on race/ethnicity, income, and immigration status.[2,16,22–24]

When compared with restrictive states, children in inclusive states were also more likely to have received preventive exams and to have less difficulty paying medical bills. This is consistent with other literature that has reported a lack of health coverage and difficulty paying medical bills as barriers to health care access.[25,26] By extension, it is logical that in those states that provide increased health coverage, families have some measure of financial protection with fewer medical costs.[15]

When comparing semi-restrictive to restrictive states, we found increased rates of preventive exams in the semi-restrictive group but no difference in the rate or continuity of insurance coverage or ability to pay medical bills. In contrast to our analysis comparing inclusive and restrictive states, our data show that the differences between semi-restrictive and restrictive states are minimal. One reason for this may be that the number of so-called "qualified" immigrants who may or may not be subject to the five-year waiting period (depending on their state's policy) is much smaller than the number of foreign-born children who do not have any access to Medicaid or CHIP in these states. While those states that only remove the five-year waiting period may improve health care access for a relatively small group of foreign-born children (primarily those with green cards), many more foreign-born children—in particular, those who are undocumented—will never be eligible for Medicaid/CHIP in 44 states under current policies. Therefore, the effect is not apparent when the entire population of foreign-born children is studied. This study shows that those states that have removed all restrictions on health coverage based on immigration status have much better scores on indicators of child health care access than those states who have only removed the five-year waiting period for "qualified" immigrants.

Our study has several limitations. Given the cross-sectional nature of the dataset, it is not possible to draw direct causal inferences between the health care access metrics examined

and state eligibility criteria. In addition, the NSCH does not inquire about immigration status, rather whether children were foreign-born or not. States with more of one type of immigrant child than others might affect health metrics in ways not captured by the NSCH or our analysis. The NSCH dataset analyzed comprises self-reported census questions, which are subject to report bias inherent in this process. Furthermore, by its nature as a paper and web-based survey, the NSCH dataset may be subject to non-response bias. Immigrant families, due to language barriers, logistical barriers, or fear in a politically charged environment may be less likely to answer and respond to surveys. [9,22]

Conclusions. Analysis of states' discrepant policies in Medicaid/CHIP eligibility for foreign-born children show that, in states with inclusive policies, children have increased and more consistent health insurance coverage, fewer problems paying medical bills, and receive more regular preventive exams than in states with restrictive policies. These data also suggest that simply removing the five-year waiting period might not be sufficient to improve health care access for most foreign-born children. To effect significant change in children's access to health care, and, in turn, long-term health outcomes, it is imperative that affordable health insurance coverage such as Medicaid/CHIP be accessible for all children, regardless of immigration status.

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