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Immigrants' Access to Health Care

December 21, 2022

Congressional Research Service
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R47351

CRS REPORT
Prepared for Members and
Committees of Congress

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Immigrants' Access to Health Care

This report discusses the eligibility criteria for noncitizen populations for various federal health care coverage programs, including Medicare, Medicaid, and Affordable Care Act subsidies for private health insurance.

Noncitizen eligibility for coverage through federal health care programs varies by program and immigration status category. Various restrictions in federal law prohibit certain noncitizens from receiving coverage through federal health care programs. In addition, some noncitizens who are eligible to work in the United States are employed in jobs that do not provide employer-based health insurance coverage. As such, some noncitizens may face challenges accessing health services due to their lack of health insurance coverage. These individuals may rely on parts of the health care safety net, such as health centers, that are required to provide care to individuals regardless of their ability to pay.

SUMMARY

R47351

December 21, 2022

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Estimating the size of the noncitizen populations is challenging because surveys more commonly ask about country of birth rather than citizenship status. As such, estimates of the foreign-born population are more readily available, but such estimates include naturalized citizens. Recent estimates from the U.S. Census Bureau found that an estimated 45.2 million foreign-born people live in the United States, representing 13.5% of the total U.S. population. More than half of this population consists of naturalized citizens. Researchers have found that the immigrant population overall tends to be in better health than the U.S.-born population across a number of conditions, including cancer and cardiovascular diseases. These findings are not uniform across the immigrant population, as groups such as refugees have higher rates of chronic conditions than do other types of immigrants and the U.S.-born population. Further, researchers have found that immigrants' health status converges with that of the U.S.-born population as the length of their residency increases.

Immigrant populations may also face barriers when seeking to access health services. These include, but are not limited to, lack of health insurance coverage, health care costs, transportation, and unpredictable work schedules. Many of these barriers are similar to those faced by native-born, low-income populations. Some barriers, like fears related to immigration status, are specific to immigrant populations. Overall, researchers have found that immigrant populations use fewer health services than the native-born U.S. population. The unauthorized population (sometimes referred to as *undocumented* or *illegal*) uses fewer services and has lower annual health-related expenditures than the authorized immigrant population, while both these groups use fewer services and have lower annual expenditures than the U.S-born population. The pattern of lower service use persists for insured immigrant populations (both authorized and unauthorized); among those who have private insurance, on average, they use less in health services than the amount paid for their coverage.

Individuals must meet general eligibility criteria for federal health care coverage programs, including applicable age and income criteria. U.S. citizens, including those who are naturalized, and legal permanent residents are generally eligible for these programs. Noncitizen eligibility varies by program and immigration status. Many programs allow specific categories of noncitizens with certain forms of legal status to access benefits, with varying restrictions. In general, unauthorized immigrants are not eligible for federal health care coverage programs.

The federal government provides direct and in-kind support for public health programs and various parts of the federal health care safety net. Facilities such as emergency departments and health centers have obligations to provide care regardless of insurance status, though they may charge for the services they provide. Federal programs also support providers that deliver family planning services and those that seek to reduce the transmission of communicable diseases. These programs generally provide services regardless of ability to pay or immigration status. Moreover, federal law provides that public health services related to communicable disease transmission be available to individuals regardless of immigration status.

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Introduction

Many noncitizens may experience challenges accessing health care services because they lack access to health insurance coverage. Additionally, federal law prohibits certain noncitizens from receiving coverage through federal health care programs (e.g., Medicaid, the State Children's Health Insurance Program (CHIP), Medicare, and subsidies for private health insurance under the Affordable Care Act (P.L. 111-148, as amended)), and some noncitizens are employed in jobs that do not provide employer-based health insurance coverage.[1] As such, these individuals may rely on parts of the health care safety net that are required to provide care to individuals regardless of their ability to pay.[2]

This report begins with a discussion of some key terms (see also the **Appendix** for a list of acronyms used in the report), and then provides a brief overview of immigrants' health status and use of health care. Next, it explores immigrants' eligibility for certain publicly funded health care programs, and it then provides information on types of health facilities where immigrants can access care.[3] The report concludes with discussion of some of the barriers that may affect immigrants' use of health services. This report is intended to inform policymaking; it is not intended as a guide to be used by individuals to determine their eligibility for specific health care benefits.

Noncitizens Definition and Population Estimates

As used in this report, the term *noncitizens* refers to individuals who are not citizens[4] of the United States (i.e., neither U.S.-born[5] nor naturalized). Estimating the size of the noncitizen population is challenging because surveys generally examine the broader foreign-born population, which includes naturalized citizens, rather than the noncitizen population specifically. As such, using the foreign-born population would overestimate the noncitizen population. Recent estimates from the U.S. Census Bureau found that an estimated 45.2 million foreign-born people

[1] Jesse Bennett, "The Share of Immigrant Workers in High-Skill Jobs is Rising the U.S.," Pew Research Center, Washington, DC, February 24, 2020, https://www.pewresearch.org/fact-tank/2020/02/24/the-share-of-immigrant-workers-in-high-skill-jobs-is-rising-in-the-u-s/. Though the number of immigrants in high-skill jobs has increased, "immigrants remain more likely than U.S.-born workers to work in lower-skill occupations." See discussion the in "Immigrants' Health Care Use" section of this CRS report.

[2] U.S. Bureau of Labor Statistics. "Lower-wage workers less likely than other workers to have medical care benefits in 2019," March 3, 2020, https://www.bls.gov/opub/ted/2020/lower-wage-workers-less-likely-than-other-workers-to-have-medical-care-benefits-in-2019.htm; and Jennifer Tolbert, Kendal Orgera, and Anthony Damico, "Key Facts about the Uninsured Population," Kaiser Family Foundation, November 6, 2020, https://www.kff.org/uninsured/issue-brief/key-facts-about-the-uninsured-population/. See discussion in the "Immigrants' Health Care Use" section of this CRS report.

[3] Noncitizens who are members of the U.S. military or are veterans may be eligible for care through the Department of Defense health care programs or the Department of Veterans Affairs. These programs are not discussed in this report.

[4] For the purposes of this report, the term U.S. citizen includes noncitizen U.S. nationals (e.g., persons born in certain U.S. territories, such as American Samoa).

[5] In some circumstances, individuals born to U.S. parents abroad can acquire U.S. citizenship at birth. For more information, see U.S. Department of State, Bureau of Consular Affairs, *Birth of U.S. Citizens and Non-Citizen Nationals Abroad*, at https://travel.state.gov/content/travel/en/international-travel/while-abroad/birth-abroad.html; and CRS Report R47223, *U.S. Citizenship for Children Born Abroad: In Brief*.

live in the United States, representing 13.5% of the total U.S. population.[6] A variety of data sources shed light on subsets of the foreign-born population. Among the foreign born population,[7]

- 24.0 million are naturalized citizens[8];
- 13.1 million are lawful permanent residents (LPRs, or *green card* holders)[9];
- 3.2 million are nonimmigrant workers, students, exchange visitors, diplomats, and their relatives[10]; and
- 11.0 million are estimated to be unauthorized immigrants.[11]

Immigration Categories

Noncitizen eligibility for certain federal health care programs depends on a program's criteria and the immigration status of the individual. The universe of immigration categories is vast; this report focuses on the categories mentioned in the laws and regulations relating to federal health care programs, including the following (in alphabetical order):

- **Adjustment of status applicants** are those applying for LPR status through U.S. Citizenship and Immigration Services (USCIS) because they are already in the United States (in contrast to those abroad, who apply for an immigrant visa from the Department of State).[12]
- **Afghan parolees** are Afghans[13] paroled into the United States between July 31, 2021, and September 30, 2022.[14]
- **Asylees** are foreign nationals fleeing their countries because of persecution, or a well-founded fear of persecution on account of race, religion, nationality, membership in a particular social group, or political opinion.[15]

[6] U.S. Census Bureau, Nativity and Citizenship Status in the United States, 2021, Table B05001, http://data.census.gov.

[7] Because the data included in this list come from various sources, they do not add up to the U.S. Census Bureau's estimate of 45.2 million foreign-born people living in the United States in 2021.

[8] U.S. Census Bureau, Nativity and Citizenship Status in the United States, 2021, Table B05001, http://data.census.gov.

[9] This number is based on the most recent estimates from the Department of Homeland Security (DHS); see Bryan Baker, "Estimates of the Lawful Permanent Resident Population in the United States and the Subpopulation Eligible to Naturalize: 2019-2021," DHS, Office of Immigration Statistics, April 2022, https://www.dhs.gov/sites/default/files/2022-05/22_0405_plcy_lpr_population_estimates_2019_-_2021.pdf.

[10] Bryan Baker, "Population Estimates of Nonimmigrants Residing in the United States: Fiscal Years 2017-2019," DHS, Office of Immigration Statistics, May 2021, at https://www.dhs.gov/sites/default/files/publications/immigration-statistics/Pop_Estimate/NI/ni_population_estimates_fiscal_years_2017_-_2019v2.pdf.

[11] Center for Migration Studies New York, "Estimates of Undocumented and Eligible-to-Naturalize Populations by State," 2021; Julia Heinzel, Rebecca Heller, and Natalie Tawil, "Estimating the Legal Status of Foreign-Born People," Congressional Budget Office (CBO), Working Paper 2021-02, March 2021; Migration Policy Institute, "Profile of the Unauthorized Population: United States," accessed May 16, 2022; Mark Hugo Lopez, Jeffrey S. Passel, and D'Vera Cohn, "Key Facts about the Changing U.S. Unauthorized Immigrant Population," Pew Research Center, April 13, 2021; and Bryan Baker, "Estimates of the Unauthorized Immigrant Population Residing in the United States: January 2015-January 2018," DHS, January 2021.

[12] For more information, see USCIS, *Adjustment of Status*, at https://www.uscis.gov/green-card/green-card-processes-and-procedures/adjustment-of-status.

[13] Or individuals with no nationality who last habitually resided in Afghanistan.

[14] Or those paroled after September 30, 2022, with a qualifying family connection (e.g., child, spouse, or parent of specified individuals).

[15] An asylee is a person who meets the definition of a refugee in terms of persecution or a well-founded fear of

- **Certain abused spouses and children** refers to certain foreign nationals who have been abused (i.e., subject to battery or extreme cruelty) in the United States by a spouse or other household member, foreign nationals whose children have been abused, and noncitizen children of foreign nationals who have been abused. In these cases, the foreign national must have been approved for, or have pending, an application with a prima facie case for immigration preference as a spouse or child or for cancellation of removal[16] (e.g., Violence Against Women Act [VAWA] Self-Petitioners).
- **Certain noncitizens who entered the United States before January 1, 1982**,[17] which refers to noncitizens who were granted temporary legal status and were then able to adjust to LPR status pursuant to IRCA.
- Refugee-like noncitizens who arrived before 1980 and were granted **conditional entry** pursuant to the Immigration and Nationality Act (INA), Section 203(a)(7).[18]
- **Cuban-Haitian Entrants** are foreign nationals admitted into the United States for humanitarian reasons.[19]
- Noncitizens with **deferred action** are those who are *inadmissible*[20] or deportable but DHS granted them a discretionary reprieve from removal.[21]

persecution but is present in the United States or at a land border or port of entry to the United States. For more information, see CRS Report R45539, *Immigration: U.S. Asylum Policy*.

[16] Deportation is referred to as *removal* in immigration law. "Cancellation of removal is an immigration benefit whereby permanent residents and non-permanent residents may apply to an immigration judge to adjust their status from that of deportable alien to one lawfully admitted for permanent residence, provided certain conditions are met"; see Cornell Law School, *Legal Information Institute,* "cancelation of removal," https://www.law.cornell.edu/wex/cancellation_of_removal#:~:text=Cancellation%20of%20removal%20is%20an,provided%20certain%20conditions%20are%20met.

[17] Pursuant to INA §245A (U.S.C. §1255a).

[18] The INA, as originally enacted in 1952, did not contain refugee or asylum provisions. Language on the conditional entry of refugees was added by the INA Amendments of 1965. The conforming definition of a refugee was added by the Refugee Act of 1980. For more information, see CRS Report R45539, *Immigration: U.S. Asylum Policy*.

[19] The term *Cuban-Haitian Entrant* is not defined in immigration law, but its usage dates back to 1980. Many of the Cubans and the vast majority of the Haitians who arrived in South Florida during the 1980 Mariel Boatlift did not qualify for asylum according to the individualized definition of persecution in 8 U.S.C. §§1157-1158. The Carter Administration labeled Cubans and Haitians as Cuban-Haitian Entrants and used the discretionary parole authority of the Attorney General to admit them to the United States. Subsequently, an adjustment of status provision was included in the Immigration Reform and Control Act of 1986 (IRCA; P.L. 99-603, §202) that enabled the Cuban-Haitian Entrants who had arrived during the Mariel Boatlift to become LPRs. While not a term in immigration law, Congress did define Cuban-Haitian Entrant in the context of eligibility for federal assistance in Title V of the Refugee Education Assistance Act of 1980 (P.L. 96-422, as amended; 8 U.S.C. §1522 note). For more information, see USCIS, Cuban Haitian Entrant Program, at https://www.uscis.gov/archive/archive-news/cuban-haitian-entrant-program-chep.

[20] The INA grounds of inadmissibility (INA §212(a), 8 U.S.C. §1182(a)) are grounds under which foreign nationals are ineligible for visas or U.S. admission. For more information, see CRS Report R45993, *Legalization Framework Under the Immigration and Nationality Act (INA)*.

[21] *Deferred action* is a generic term that DHS uses for a decision not to remove an inadmissible or deportable noncitizen pursuant to its enforcement discretion. For more information, see CRS Report R45158, *An Overview of Discretionary Reprieves from Removal: Deferred Action, DACA, TPS, and Others*.

- **Deferred Action for Childhood Arrivals (DACA)** recipients are unauthorized childhood arrivals who DHS granted renewable two-year protection from removal.[22]
- **Deferred Enforced Departure (DED)** recipients are foreign nationals from countries who have been granted a temporary administrative stay of removal at the President's discretion, usually in response to war, civil unrest, or natural disasters.[23]
- **Family Unity Beneficiaries** are spouses and unmarried children of legalization applicants who have resided in the United States since May 5, 1988, pursuant to the Immigration Act of 1990 (§301 of P.L. 101-649, as amended).
- **Freely Associated States (FAS) migrants** are citizens of the Marshall Islands, Micronesia, or Palau permitted to live in the United States indefinitely under the terms of those nations' Compacts of Free Association (COFA) with the United States.[24]
- **Noncitizens admitted to the United States**, which can refer to any noncitizen who was lawfully admitted (e.g., as a nonimmigrant or refugee).[25]
- **Iraqi and Afghan special immigrants** are certain Iraqi and Afghan nationals who worked as translators or interpreters, or who were employed by, or on behalf of, the U.S. government in Iraq or Afghanistan and were eligible for a special immigrant visa (SIV), which enables them to become LPRs.[26]
- **LPRs** are foreign nationals permitted to live in the United States permanently.[27]
- The INA does not define **lawfully present** noncitizens. Various health care programs utilize this term, but it has different meanings depending on the statutory or regulatory definition utilized for each program. (If applicable, the definition utilized by the programs discussed in this report is explained in the relevant section.)
- **Nonimmigrants** are foreign nationals admitted to the United States on a temporary basis and for a specific purpose (e.g., tourists, students, diplomats, temporary workers).[28]
- **Parolees** are foreign nationals granted permission to enter or remain temporarily in the United States for urgent humanitarian reasons or significant public benefit. Immigration parole is granted on a case-by-case basis.[29]

[22] For more information, see CRS Report R45995, *Unauthorized Childhood Arrivals, DACA, and Related Legislation*.

[23] For more information, see CRS Report RS20844, *Temporary Protected Status and Deferred Enforced Departure*.

[24] For background information on the compacts, see CRS Report RL31737, *The Marshall Islands and Micronesia: Amendments to the Compact of Free Association with the United States*.

[25] For more information, see USCIS, *Policy Manual*, "Chapter 2 - Eligibility Requirements," at https://www.uscis.gov/policy-manual/volume-7-part-b-chapter-2.

[26] For more information, see CRS Report R43725, *Iraqi and Afghan Special Immigrant Visa Programs*.

[27] For more information, see CRS Report R42866, *Permanent Legal Immigration to the United States: Policy Overview*.

[28] For more information, see CRS Report R45040, *Immigration: Nonimmigrant (Temporary) Admissions to the United States.*

[29] For more information, see CRS Report R46570, *Immigration Parole*.

- **Refugees** are foreign nationals fleeing their countries because of persecution, or a well-founded fear of persecution, on account of race, religion, nationality, membership in a particular social group, or political opinion.[30]
- **Special Agricultural Workers** are certain individuals granted legal status through the Immigration Reform and Control Act of 1986 (IRCA; P.L. 93-603). The law granted eligible individuals temporary residence; they could later apply for permanent residence.[31]
- **Special Immigrant Juveniles (SIJs)** are children under age 21 who were born in a foreign country; live without legal authorization in the United States; have experienced abuse, neglect, or abandonment; and meet other specified eligibility criteria.[32]
- **Temporary Protected Status (TPS)** holders are foreign nationals granted temporary relief from removal due to armed conflict, natural disaster, or other extraordinary circumstances in their home countries that prevent their safe return.[33]
- **Ukrainian parolees** are Ukrainians[34] paroled into the United States between February 24, 2022, and September 30, 2023.[35]
- **Victims of human trafficking** and their families who have received a T nonimmigrant status are foreign nationals who can live in the United States for up to four years; they may apply for LPR status after three years.[36]
- Noncitizens who have **violated the terms of their status**[37] (e.g., a nonimmigrant who worked without authorization or overstayed their visa).
- Certain foreign nationals present in the United States may be granted **withholding of removal** based on persecution on account of race, religion, nationality, membership in a particular social group, or political opinion. Withholding of removal provides protection from removal. Noncitizens can also be granted **withholding of removal under the Convention Against Torture (CAT)** due to the prohibition against removing noncitizens to any country in which there is substantial reason to believe they could be tortured.[38]

[30] For more information, see CRS Report RL31269, *Refugee Admissions and Resettlement Policy*. What differentiates refugees from asylees is that refugee applicants are outside the United States, while applicants for asylum are physically present in the United States or at a land border or port of entry.

[31] INA §210; 8 U.S.C. §1160.

[32] For more information, see CRS Report R43703, *Special Immigrant Juveniles: In Brief*.

[33] For more information, see CRS Report RS20844, *Temporary Protected Status and Deferred Enforced Departure*.

[34] Or non-Ukrainian individuals who habitually resided in Ukraine.

[35] Or those individuals' spouses or unmarried children under age 21 who are paroled into the United States after September 30, 2023.

[36] For more information, see CRS Report R46584, *Immigration Relief for Victims of Trafficking*.

[37] USCIS, *Policy Manual*, "Chapter 4 - Status and Nonimmigrant Visa Violations (INA 245(c)(2) and INA 245(c)(8)" at https://www.uscis.gov/policy-manual/volume-7-part-b-chapter-4.

[38] For more information, see CRS Report R45993, *Legalization Framework Under the Immigration and Nationality Act (INA)*.

Health Status of Immigrants

Health status "[r]efers to your medical conditions (both physical and mental health), claims experience, receipt of health care, medical history, genetic information, evidence of insurability, and disability."[39] Research on immigrant populations generally looks at country of birth. As such, some studies may include individuals who have immigrated to the United States but are naturalized citizens or LPRs and therefore eligible for the programs discussed in this report. Studies show that, at a population level, immigrants living in the U.S. tend to have better health status than native-born U.S. citizens.[40]

The National Academies of Sciences, Engineering, and Medicine (NASEM), reviewed the existing literature on immigrants in the United States and their health status in 2015 and found the following:

> Comprehensive analyses on immigrant health status using eight federal national datasets show that immigrants have better infant, child, and adult health outcomes than the native-born in general and the native-born members of the same ethnoracial groups (Singh et al., 2013). Immigrants, compared to the native-born, are less likely to die from cardiovascular disease and all cancers combined and have a lower incidence of all cancers combined, fewer chronic health conditions, lower infant mortality rates, lower rates of obesity, lower percentages who are overweight, fewer functional limitations, and fewer learning disabilities.[41]

These health advantages might decrease the longer immigrants reside in the United States. According to NASEM, "Research has documented higher rates of different health problems including hypertension, chronic illness, smoking, diabetes, and heavy alcohol use as length of residency increases."[42] Other studies have also demonstrated that immigrants' health status converges with the rest of the U.S. population the longer they reside in the United States.[43] The health status of immigrants is not uniform and may vary, for example, by immigration pathway. Researchers found that refugees have higher rates of chronic conditions compared to other types of immigrant populations and the U.S.-born population.[44]

Immigrants' Health Care Use

Though immigrant populations have access to some types of health services, researchers have found that both authorized and unauthorized immigrants use less health care than the U.S.-born population. For example, in a study of national health care use between 2016 and 2017, the authors found that unauthorized immigrants had fewer visits and lower annual per person

[39] Healthcare.gov, "Health Status," https://www.healthcare.gov/glossary/health-status/#:~:text=Refers%20to%20your%20medical%20conditions,evidence%20of%20insurability%2C%20and%20disability.

[40] This information is intended to give an overview of health status; it is not comprehensive.

[41] National Academies of Sciences, Engineering, and Medicine, *The Integration of Immigrants into American Society*. (Washington, DC: The National Academies Press, 2015), p. 378, https://doi.org/10.17226/21746.

[42] Ibid, p. 385.

[43] See, for example, Heather Antecol and Kelly Bedard, "Unhealthy Assimilation: Why Do Immigrants Converge to American Health Status Levels?" *Demography*, vol. 43, no. 2 (March 2006), pp. 337-360.

[44] Gayathri S. Kumar et al., "Long-Term Physical Health Outcomes of Resettled Refugee Populations in the United State: A Scoping Review," *Journal of Immigrant and Minority Health*, vol. 23 (January 30, 2021), pp. 813-823. See also, Holly E. Reed and Guillermo Yrizar Barbosa, "Investigating the Refugee Health Disadvantage Among the U.S. Immigrant Population," *Journal of Immigration & Refugee Studies*, vol. 15, no. 1 (2017), pp. 53-70.

expenditures compared to authorized immigrants, and that the U.S.-born population had the highest number of visits and per person expenditures compared to both authorized and unauthorized immigration populations.[45] In other studies using 2016-2017 national data, researchers also found that expenditures were lower for immigrant populations (both authorized and unauthorized) and that immigrants paid more in out-of-pocket expenses than U.S.-born individuals. The higher out-of-pocket expenditures are due to lower rates of insurance coverage among immigrant populations.[46] Other researchers have found that immigrants who do have private insurance coverage, on average, use less in health services than the amount they paid for their coverage.[47]

Public and Private Health Insurance Coverage

According to one study, in 2020, over a quarter (26%) of nonelderly lawfully present immigrants were uninsured, as were 42% of non-elderly unauthorized immigrants.[48] In comparison, 8% of nonelderly U.S. citizens were uninsured in 2020.[49]

There are multiple reasons why the uninsured rate among noncitizens is disproportionally high. First, private health insurance is the predominant source of health insurance coverage in the United States. Private health insurance is provided through both the group market (i.e., health insurance coverage that is mostly sponsored by employers) and through the non-group or individual market. Group market coverage is the source of health insurance coverage for more than half of the U.S. population.[50] Certain noncitizens may have limited access to employer-sponsored coverage because they are over-represented in low-skilled occupations,[51] where they are less likely to be offered subsidized health coverage. Second, because of their low pay, they may have difficulty affording private, unsubsidized health insurance.[52] Third, noncitizens may have limited access to public health care coverage depending on their immigration status. As explained in the sections below, many noncitizens are excluded from non-emergency[53]

[45] Fernando A. Wilson et al., "Comparison of Use of Health Care Services and Spending for Unauthorized Immigrants vs. Authorized Immigrants or US Citizens Using a Machine Learning Model," *JAMA Network Open*, vol. 3, no. 12 (December 11, 2020).

[46] Lila Flavin, et al., "Medical Expenditures on and by Immigrant Populations in the United States: A Systematic Review," *International Journal of Health Services*, vol. 48, no. 4 (August 8, 2018), pp. 601-621.

[47] Leah Zallman et al., "Immigrants Pay More in Private Insurance Premiums Than They Receive in Benefits," *Health Affairs*, vol. 37, no. 10 (October 2018).

[48] Kaiser Family Foundation (KFF), "Health Coverage of Immigrants," April 6, 2022, Figure 3, https://www.kff.org/racial-equity-and-health-policy/fact-sheet/health-coverage-of-immigrants/. See also "Appendix A: Lawfully Present immigrants by Qualified Status" to see immigration categories included in KFF's definition of *lawfully present*.

[49] Ibid.

[50] See CRS In Focus IF10830, *U.S. Health Care Coverage and Spending*.

[51] Jesse Bennett, *The Share of Immigrant Workers in High-Skill Jobs is Rising the U.S.*, Pew Research Center, Washington, DC, February 24, 2020, https://www.pewresearch.org/fact-tank/2020/02/24/the-share-of-immigrant-workers-in-high-skill-jobs-is-rising-in-the-u-s/. Though the number of immigrants in high-skill jobs has risen, "immigrants remain more likely than U.S.-born workers to work in lower-skill occupations."

[52] U.S. Bureau of Labor Statistics. "Lower-wage workers less likely than other workers to have medical care benefits in 2019." March 3, 2020, at https://www.bls.gov/opub/ted/2020/lower-wage-workers-less-likely-than-other-workers-to-have-medical-care-benefits-in-2019.htm; Jennifer Tolbert, Kendal Orgera, and Anthony Damico, "Key Facts about the Uninsured Population," *Kaiser Family Foundation*, November 6, 2020, at https://www.kff.org/uninsured/issue-brief/key-facts-about-the-uninsured-population/.

[53] Under emergency Medicaid (Social Security Act §1903(v)(3) [42 U.S.C. §1396b(v)(3) and 8 U.S.C. §1611(b)(1)(A)]), states are required to provide limited Medicaid services for the treatment of an emergency medical

Medicaid.[54] They may also be excluded from using health care subsidies through the Patient Protection and Affordable Care Act (ACA, P.L. 111-148, as amended).[55] Finally, they may not be eligible to purchase unsubsidized health care on ACA exchanges.[56]

Health Coverage Eligibility

This section reviews noncitizen eligibility for federally funded health insurance programs.[57] It also includes a discussion of noncitizen eligibility for financial subsidies made available through the ACA.

Title IV of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA)

Title IV of PRWORA created a "national policy with respect to welfare and immigration."[58] Enacted on August 22, 1996, PRWORA amended immigration law to establish an overarching set of noncitizen eligibility requirements for most federal public benefits. Subsequent amendments from 1996 through 1998 modified PRWORA's requirements to form the basic framework that applies today.[59] While PRWORA created blanket noncitizen eligibility requirements, noncitizen eligibility is not uniform across federal public benefit programs because PRWORA interacts with other laws, regulations, and guidance that govern each individual program.[60]

PRWORA defines *federal public benefit* to include "any retirement, welfare, health, disability ... or any other similar benefit for which payments or assistance are provided to an individual, household, or family eligibility unit by an agency of the United States or by appropriated funds of

condition to otherwise eligible noncitizens, regardless of immigration status or lack of immigration status. For pregnant women, emergency Medicaid includes services covered under the state plan (e.g., routine prenatal care, labor and delivery, and routine postpartum care) (42 C.F.R. §440.255(b)(2)).

[54] Other barriers to Medicaid coverage are discussed in the "Effect of the Public Charge Rule" section of this report.

[55] Healthcare.gov, "Subsidized Coverage," https://www.healthcare.gov/glossary/subsidized-coverage/. See also CRS Report R44425, *Health Insurance Premium Tax Credit and Cost-Sharing Reductions*.

[56] Healthcare.gov, "Immigrants: Healthcare Coverage for Immigrants," https://www.healthcare.gov/immigrants/coverage/. For an overview of health care exchanges, see CRS Report R44065, *Overview of Health Insurance Exchanges*.

[57] Other federal programs include insurance benefits made available to those in the armed services (i.e., Defense Health Programs) and services provided by the Department of Veteran Affairs (VA) for individuals who have served in the military and meet the VA's eligibility criteria. In accordance with federal law, U.S. citizens, noncitizen nationals (individuals born in American Samoa and Swains Island), and LPRs are eligible to enlist in the U.S. Armed Forces. Persons from Micronesia, the Marshall Islands, and Palau are also eligible to enlist. There is also legal authority for those who do not fall into these categories to enlist in certain circumstances. Noncitizens who are eligible to serve in the Armed Forces thereby may be eligible for defense health care. The Indian Health Service also provides services to members of federally recognized tribes. In limited instances, federally recognized tribes span the U.S.-Canada or U.S.-Mexico border. As such, the relevant Indian Health Service facility may provide some services to tribal members regardless of U.S. citizenship status in these instances.

[58] 8 U.S.C. §1601.

[59] See Title V of the Illegal Immigration Reform and Immigrant Responsibility Act of 1996 (IIRIRA; P.L. 104-208, Division C), Title V of the Balanced Budget Act of 1997 (BBA 97; P.L. 105-33), and the Noncitizen Benefit Clarification and Other Technical Amendments Act of 1998 (P.L. 105-306).

[60] For more information, see CRS Report R46510, *PRWORA's Restrictions on Noncitizen Eligibility for Federal Public Benefits: Legal Issues*.

the United States."[61] PRWORA exempts certain types of programs, usually thought of as emergency programs, from its noncitizen eligibility requirements.[62] In addition, PRWORA makes an exception "for immunizations with respect to immunizable diseases and for testing and treatment of symptoms of communicable diseases."[63]

PRWORA states that aliens, unless they are qualified aliens (see the "Qualified Alien" section), are ineligible for federal public benefits. In addition, PRWORA places a number of restrictions on qualified aliens' eligibility for certain federal means-tested public benefits (FMTPBs), including Medicaid.[64]

Qualified Alien

As noted above, PRWORA states that aliens are ineligible for federal public benefits unless they are qualified aliens.[65] PRWORA created the term *qualified alien*,[66] which did not previously exist in immigration law. Qualified aliens are

- LPRs,
- noncitizens granted asylum,
- refugees,
- noncitizens paroled into the United States for at least one year,
- noncitizens granted withholding of removal,
- noncitizens granted conditional entry before 1980,
- Cuban-Haitian entrants, and
- certain abused spouses and children.

Another group is considered qualified aliens, but only with respect to Medicaid:

- Citizens of the FAS residing in the U.S. states and territories.[67]

[61] 8 U.S.C. §1611(c)(1).

[62] This includes short-term, in-kind emergency disaster relief and services or assistance designated by the Attorney General as (1) delivering in-kind services at the community level, (2) providing assistance without individual determinations of each recipient's needs, and (3) being necessary for the protection of life and safety. Noncitizens who do not meet the definition of *qualified aliens* are eligible for these emergency programs.

[63] 8 U.S.C. §1611(b)(1)(C).

[64] FMTPBs are programs where eligibility is partially based on household income. These include Supplemental Security Income (SSI), Temporary Assistance for Needy Families (TANF), the Supplemental Nutrition Assistance Program (SNAP), non-emergency Medicaid, and the State Child Health Insurance Program (CHIP). Many qualified aliens are barred from FMTPBs for five years. In addition, many qualified aliens are subject to sponsor deeming, meaning that a portion of the income and resources of the immigrant's sponsor are used to determine whether the noncitizen meets the financial eligibility requirements of the FMTPBs. Moreover, if the noncitizen receives FMTPBs, the granting agency can seek reimbursement from the immigrant's sponsor. Some categories of noncitizens are not subject to these stricter rules for FMTPBs, including refugees, asylees, Cuban-Haitian entrants, and noncitzens granted withholding of removal. For more information, see CRS Report RL33809, *Noncitizen Eligibility for Federal Public Assistance: Policy Overview*.

[65] 8 U.S.C. §1611(a).

[66] 8 U.S.C. §1641(b).

[67] The Consolidated Appropriations Act, 2021 (P.L. 116-260) modified PRWORA by adding FAS citizens who are lawfully residing in the United States under COFA to the list of qualified aliens, but, as noted above, only with respect to Medicaid. For more information, see CRS In Focus IF11912, *Noncitizen Eligibility for Medicaid and CHIP*.

Other groups of noncitizens who are not qualified aliens but may be eligible for federal public benefits under other laws include

- certain victims of human trafficking,[68]
- Iraqi and Afghan special immigrants,[69] and
- certain Afghan[70] and Ukrainian[71] parolees.

Nonqualified aliens are all other noncitizens, including nonimmigrants, DACA recipients, TPS holders, recipients of DED, short-term (less than one year) parolees, asylum applicants, various other classes of noncitizens granted temporary permission to remain in the United States, and unauthorized immigrants. Nonqualified aliens are ineligible for most federal public benefits.

Medicaid and CHIP

Medicaid and CHIP provide a health care safety net for low-income populations. Medicaid is a joint federal-state program that finances the delivery of primary and acute medical services, as well as long-term services and supports, to a diverse low-income population, including children, pregnant women, adults, individuals with disabilities, and people aged 65 and older.[72] CHIP provides health insurance coverage to low-income, uninsured children (through age 18) in families with incomes above applicable Medicaid income standards, as well as to certain pregnant women.[73]

Generally, the following qualified aliens are eligible for Medicaid and CHIP:

- LPRs,
- noncitizens granted asylum,
- refugees,
- noncitizens paroled into the United States for at least one year,
- noncitizens granted withholding of removal,

[68] Subsequent to the enactment of PRWORA, lawmakers enacted the Victims of Trafficking and Violence Protection Act of 2000 (P.L. 106-386). Although this law did not amend PRWORA, it made victims of trafficking eligible for benefits and services "under any Federal or State program" to the same extent as refugees. As a result, victims of trafficking may be eligible for Medicaid and CHIP.

[69] Iraqi and Afghan special immigrants are treated like refugees for purposes of federal public benefits. The Refugee Crisis in Iraq Act of 2007 (P.L. 110-181, as amended), and the Afghan Allies Protection Act of 2009 (P.L. 111-8, Division F, Title IV, as amended) enabled certain Iraqi and Afghan nationals to become eligible for an SIV and qualify for the same federal assistance available to refugees. Consequently, Iraqi and Afghan special immigrants may be eligible for Medicaid and CHIP.

[70] After the elected Afghan government's collapse and Taliban takeover in August 2021, Congress passed the Extending Government Funding and Delivering Emergency Assistance Act (P.L. 117-43, Division C, §2502), which provided certain Afghan parolees with benefits to the same extent as refugees until March 31, 2023, or the end of their parole term, whichever is later.

[71] In response to Russia's renewed invasion of Ukraine in February 2022, Congress passed Additional Ukraine Supplemental Appropriations Act, 2022 (P.L. 117-128, Title IV, §401), which provided certain Ukrainian parolees with benefits to the same extent as refugees (with the exception of the initial resettlement program [i.e., the State Department's Reception and Placement Program]) until the end of their parole term.

[72] All Medicaid applicants must meet federal and state requirements regarding residency, immigration status, and documentation of U.S. citizenship.

[73] CHIP applicants must meet CHIP eligibility requirements including residency, immigration status, and/or documentation of U.S. citizenship.

- noncitizens granted conditional entry before 1980,
- Cuban-Haitian entrants,
- certain abused spouses and children, and
- citizens of the FAS residing in the U.S. states and territories.[74]

Other groups of noncitizens who are not qualified aliens but are eligible for Medicaid and CHIP under different laws include

- certain victims of human trafficking,[75]
- Iraqi and Afghan special immigrants,[76] and
- certain Afghan[77] and Ukrainian[78] parolees.

There are additional Medicaid eligibility restrictions for qualified aliens. Many qualified aliens, such as LPRs entering the United States after August 22, 1996, are prohibited from receiving Medicaid for the first five years after entry/grant of status (often referred to as the *five-year bar*).[79] States may choose to cover LPRs within the five-year bar period and other ineligible foreign nationals (i.e., nonqualified aliens) using state-only funds for individuals, services not otherwise covered under Medicaid or CHIP, or both.[80] Refugees and asylees are eligible for Medicaid for the first seven years after arrival.[81] Subsequently, they may be eligible for Medicaid at a state's option.

With some exceptions, nonqualified aliens (see the "Qualified Alien" section above) are generally barred from Medicaid and CHIP.[82]

[74] The Consolidated Appropriations Act, 2021 (P.L. 116-260) modified PRWORA by adding FAS citizens who are lawfully residing in the United States under COFA to the list of qualified aliens, but only with respect to Medicaid. For more information, see CRS In Focus IF11912, *Noncitizen Eligibility for Medicaid and CHIP*.

[75] Subsequent to the enactment of PRWORA, lawmakers enacted P.L. 106-386. Although this law did not amend PRWORA, it made victims of trafficking eligible for benefits and services "under any Federal or State program" to the same extent as refugees. As a result, victims of trafficking may be eligible for Medicaid and CHIP.

[76] Iraqi and Afghan special immigrants are treated like refugees for purposes of federal public benefits. P.L. 110-181, as amended, and P.L. 111-8 (Division F, Title IV, as amended) enabled certain Iraqi and Afghan nationals to become eligible for an SIV and qualify for the same federal assistance available to refugees. Consequently, Iraqi and Afghan special immigrants may be eligible for Medicaid and CHIP.

[77] After the elected Afghan government's collapse and Taliban takeover in August 2021, Congress passed P.L. 117-43 (Division C, §2502), which provided certain Afghan parolees with benefits to the same extent as refugees until March 31, 2023, or the end of their parole term, whichever is later. Consequently, these Afghan parolees may be eligible for Medicaid and CHIP.

[78] In response to Russia's renewed invasion of Ukraine in February 2022, Congress passed P.L. 117-128 (Title IV, §401), which provided certain Ukrainian parolees with benefits to the same extent as refugees (with the exception of the initial resettlement program [i.e., the State Department's Reception and Placement Program]) until the end of their parole term. Consequently, these Ukrainian parolees may be eligible for Medicaid and CHIP.

[79] 8 U.S.C. §1613. However, some groups are exempt from the five-year bar (8 U.S.C. §1612).

[80] States may choose to use their funds to provide health care coverage to immigrant populations who are not eligible for federal programs. For example, six states provide comprehensive coverage to low-income children while other states provide coverage for a more limited set of services or provide Medicaid coverage to immigrant populations using only state funds to finance this coverage. See Kaiser Family Foundation, "Health Coverage of Immigrants," April 6, 2022, https://www.kff.org/racial-equity-and-health-policy/fact-sheet/health-coverage-of-immigrants/.

[81] 8 U.S.C. §1612.

[82] 8 U.S.C. §1611. For more information on the exceptions, see CRS In Focus IF11912, *Noncitizen Eligibility for Medicaid and CHIP*.

Affordable Care Act (ACA) Health Insurance Exchanges

The ACA required all states to establish health insurance exchanges (HIEs) for individuals to shop for private health insurance coverage. The exchanges are federal- and state-run virtual marketplaces through which consumers can purchase coverage directly from private insurers.[83]

Consumers may purchase coverage in their state's exchange as long as they (1) meet state residency requirements;[84] (2) are not incarcerated, except individuals in custody pending the disposition of charges; and (3) are U.S. citizens, U.S. nationals,[85] or *lawfully present* residents. Other noncitizens, including unauthorized individuals, are prohibited from purchasing coverage through the exchanges, even if they pay the entire premium without financial assistance.

Consumers purchasing coverage through the individual exchanges may be eligible to receive financial assistance that reduces the cost of purchasing coverage. Eligibility for such assistance is primarily income-based and assistance is provided in the form of premium tax credits (PTCs) and cost-sharing reductions.[86] Because the ACA prohibits noncitizens who are not legally present (see below) from obtaining exchange coverage, these individuals are not eligible for the PTC. Although certain individuals are not eligible to enroll in exchanges due to incarceration or legal status, their family members may still receive the PTC as long as those family members meet all eligibility criteria.

Noncitizen eligibility to purchase exchange plans and receive subsidies is governed by the term *lawfully present*.[87] While this term is not defined in statute, the regulations implementing exchange standards define it to include the following:

- qualified aliens (see the "Qualified Alien" section above)
  - LPRs,
  - noncitizens granted asylum,
  - refugees,
  - noncitizens paroled into the United States for at least one year,
  - noncitizens granted withholding of removal,
  - noncitizens granted conditional entry before 1980,
  - Cuban-Haitian entrants, and
  - certain abused spouses and children;
- nonimmigrants;

[83] For more information about these *individual exchanges* and other types of exchanges, such as for small businesses, see CRS Report R44065, *Overview of Health Insurance Exchanges*.

[84] State residency may be established through a variety of means, including actual or planned residence in a state, actual or planned employment in a state, and other circumstances. See 45 C.F.R. §155.305.

[85] U.S. nationals are persons born in certain U.S. territories, such as American Samoa.

[86] To be eligible to receive the PTC, individuals must meet specified criteria, including having an annual household income at or above 100% of the federal poverty level (FPL). However, there are exceptions to that threshold, including one for lawfully present aliens with incomes below 100% of FPL who are not eligible for Medicaid for the first five years they are lawfully present. The ACA established Section 36B(c)(1)(B) of the Internal Revenue Code to allow such lawfully present aliens to be eligible for PTCs. For more information, see CRS Report R44425, *Health Insurance Premium Tax Credit and Cost-Sharing Reductions*.

[87] 42 U.S.C. §18032(a,f); 45 C.F.R. §155.20, citing 45 C.F.R. §152.2.

- noncitizens paroled into the United States for less than one year (with some exceptions);
- certain noncitizens in temporary resident status as special agricultural workers[88] or because they are certain individuals who entered the United States before January 1, 1982[89];
- recipients of TPS[90];
- certain noncitizens who have been granted work authorization (e.g., adjustment of status applicants, applicants for cancelation for removal)[91];
- family unity beneficiaries[92];
- DED recipients;
- noncitizens with deferred action (excluding DACA recipients);
- noncitizens whose visa petitions have been approved and who have a pending adjustment of status application;
- applicants for asylum or withholding of removal under 8. U.S.C. §1231(b)(3) or under the CAT who have been granted employment authorization[93];
- noncitizens granted withholding of removal under the CAT; and
- noncitizens with a pending SIJ application.

The following noncitizens are not specifically mentioned in the regulations but are eligible for ACA HIEs under other laws:

- certain victims of human trafficking,[94]
- Iraqi and Afghan special immigrants,[95] and
- certain Afghan[96] and Ukrainian[97] parolees.

[88] Pursuant to INA §210 (U.S.C. §1160).

[89] Pursuant to INA §245A (U.S.C. §1255a).

[90] As well as TPS applicants who have been granted employment authorization.

[91] This refers to noncitizens granted employment authorization under 8 C.F.R. §274a.12(c)(9),(10),(16),(18),(20),(22), or (24).

[92] Pursuant to §301 of P.L. 101-649, as amended.

[93] Or are under the age of 14 and have had a pending application for at least 180 days.

[94] Subsequent to the enactment of PRWORA, lawmakers enacted P.L. 106-386. Although this law did not amend PRWORA, it made victims of trafficking eligible for benefits and services "under any Federal or State program" to the same extent as refugees. As a result, victims of trafficking may be eligible to purchase health insurance policies on the exchanges.

[95] Iraqi and Afghan special immigrants are treated like refugees for purposes of federal public benefits. P.L. 110-181, as amended, and P.L. 111-8 (Division F, Title IV, as amended) enabled certain Iraqi and Afghan nationals to become eligible for an SIV and qualify for the same federal assistance available to refugees. Consequently, Iraqi and Afghan special immigrants may be eligible to purchase health insurance policies on the exchanges.

[96] After the elected Afghan government's collapse and Taliban takeover in August 2021, Congress passed P.L. 117-43 (Division C, §2502), which provided certain Afghan parolees with benefits to the same extent as refugees until March 31, 2023, or the end of their parole term, whichever is later. Consequently, these Afghan parolees may be eligible to purchase health insurance policies on the exchanges.

[97] In response to Russia's renewed invasion of Ukraine in February 2022, Congress passed P.L. 117-128 (Title IV, §401), which provided certain Ukrainian parolees with benefits to the same extent as refugees (with the exception of the initial resettlement program [i.e., the State Department's Reception and Placement Program]) until the end of their parole term. Consequently, these Ukrainian parolees may be eligible to purchase health insurance policies on the

All other noncitizens, including unauthorized immigrants, are generally not eligible to purchase plans through the HIEs, with or without subsidies. However, states can apply to the Centers for Medicare and Medicaid Services in HHS to waive certain exchange provisions, including the lawfully present provision. Recently, Washington State was granted permission to waive this provision in order to provide residents with access to exchange coverage regardless of immigration status.[98] Separately, Colorado sought a waiver to allow the state to provide state-based financial assistance to those who are ineligible for PTCs due to immigration status.[99]

Medicare

Medicare is a federal program that pays for the covered health care services of most individuals aged 65 and older, certain disabled individuals under age 65, and certain other individuals.[100] Medicare, which consists of four parts (A-D), covers hospitalizations, physician services, prescription drugs, skilled nursing facility care, home health visits, and hospice care, among other services. Most individuals are entitled to premium-free Part A (which covers hospital care and other services) based on their entitlement to or eligibility for Social Security benefits or most railroad retirement annuities, or because they (or their eligible family members) worked for a sufficient period in covered employment. Entitlement to premium-free Part A generally allows individuals to enroll in other parts of Medicare, subject to certain other requirements.

Generally, any noncitizen who meets Medicare's standard eligibility requirements is entitled to premium-free Part A and is eligible to enroll in Part B. However, noncitizens must be lawfully present in the United States to be eligible to *receive* premium-free Part A or Part B benefits.[101] Additionally, noncitizens must be lawfully present in the United States to be eligible to enroll in Part C or Part D.[102]

Individuals aged 65 and older who are not entitled to premium-free Part A may qualify for Medicare under special provisions.[103] Such individuals may enroll in Part B and enroll in Part A by paying a premium if they are U.S. residents and either (1) U.S. citizens or (2) LPRs who have continuously resided in the United States for the five years prior to the first month of eligibility.[104]

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exchanges.

[98] See CMS, "Washington: State Innovation Waiver," December 9, 2022, WA 1332 Waiver Fact Sheet_Final, https://www.cms.gov/files/document/1332-wa-fact-sheet.pdf.

[99] As of the cover date of this report, Colorado's and Washington's waiver applications were approved. Waiver applications can be found at the CMS website, "Section 1332: State Innovation Waivers," at https://www.cms.gov/CCIIO/Programs-and-Initiatives/State-Innovation-Waivers/Section_1332_State_Innovation_Waivers-.html. For background on the Section 1332 waiver process, see CRS Report R44760, *State Innovation Waivers: Frequently Asked Questions*.

[100] For more information on Medicare, see CRS Report R40425, *Medicare Primer*.

[101] 8 U.S.C. §1611(b)(3) and HHS, Centers for Medicare & Medicaid Services, "Medicare Program; Contract Year 2016 Policy and Technical Changes to the Medicare Advantage and the Medicare Prescription Drug Benefit Programs," 80 *Federal Register* 7919-7920, February 12, 2015, https://www.federalregister.gov/documents/2015/02/12/2015-02671/medicare-program-contract-year-2016-policy-and-technical-changes-to-the-medicare-advantage-and-the. See also Social Security Administration (SSA), *Program Operations Manual System (POMS)*, "RS 00204.010 Lawful Presence Payment Provisions," April 7, 2020, https://secure.ssa.gov/poms.nsf/lnx/0300204010.

[102] 42 C.F.R. §§422.50(a)(7) and 423.30(a)(1)(iii). See also 80 *Federal Register* 7920.

[103] Individuals aged 65 or older may not qualify for premium-free Part A because they are not entitled to or eligible for Social Security benefits or most railroad retirement annuities, or because they (or their eligible family members) did not work for a sufficient period in covered employment.

[104] 42 U.S.C. §§1395i-2(a) and 1395o(a), 42 C.F.R. §§406.11(b)(2) and 407.10(a)(2), and SSA, POMS, "GN 00303.800 Eligibility Under the HI/SMI Program for Uninsured Individuals," August 7, 2006, https://secure.ssa.gov/

Individuals who enroll in Part B (or Parts A and B) under these special provisions may enroll in other parts of Medicare. For purposes of the special provisions, LPRs are subject to the same lawful-presence requirements mentioned previously.[105] The special provisions do not apply to any other noncitizens.[106]

Noncitizens determined to be *lawfully present in the United States* for Medicare purposes include the following:[107]

- qualified aliens (see the "Qualified Alien" section above)
  - LPRs,
  - noncitizens granted asylum,
  - refugees,
  - noncitizens paroled into the United States for at least one year,
  - noncitizens granted withholding of removal,
  - noncitizens granted conditional entry before 1980,
  - Cuban-Haitian entrants, and
  - certain abused spouses and children;
- noncitizens who have been inspected and admitted to the United Status and have not violated the terms of their status;
- noncitizens paroled into the United States for less than one year (with some exceptions);
- certain noncitizens in temporary resident status as special agricultural workers[108] or certain individuals who entered the United States before January 1, 1982[109];
- recipients of TPS and TPS applicants who have been granted work authorization;
- Family unity beneficiaries[110];
- DED recipients;
- noncitizens with deferred action (including DACA recipients[111]);
- noncitizen spouses or children of U.S. citizens with an approved visa petition who have a pending application for adjustment of status; and

poms.nsf/lnx/0200303800. Individuals aged 65 and older who are not entitled to premium-free Part A must be enrolled in Part B to be eligible to enroll in Part A by paying a premium.

[105] 80 *Federal Register* 7920.

[106] The special provisions that permit individuals aged 65 and older who are not entitled to premium-free Part A to enroll in Part B and enroll in Part A by paying a premium do not apply to noncitizens aged 65 and older who are not LPRs. (LPRs are qualified aliens and are by definition lawfully present in the United States for purposes of Medicare.) In addition, these provisions generally do not apply to individuals under age 65, regardless of their citizenship or immigration status.

[107] 8 C.F.R. §1.3 (formerly 8 C.F.R. §103.12). Medicare uses the definition of *lawfully present in the United States* that applies to Social Security. See 80 *Federal Register* 7919-7920 and 7922. See also SSA, POMS, "RS 00204.010 Lawful Presence Payment Provisions."

[108] Pursuant to INA §210 (8 U.S.C. §1160).

[109] Pursuant to INA §245A (8 U.S.C. §1255a).

[110] Pursuant to §301 of P.L. 101-649, as amended.

[111] 8 C.F.R. §236.21(c)(3).

- applicants for asylum or withholding of removal under 8. U.S.C. §1231(b)(3) or under the CAT who have been granted employment authorization.[112]

The following noncitizens are not specifically mentioned in the lawful-presence regulations but may be eligible for Medicare under other laws:

- certain victims of human trafficking,[113]
- Iraqi and Afghan special immigrants,[114] and
- certain Afghan[115] and Ukrainian[116] parolees.

All other noncitizens, including unauthorized immigrants, are ineligible to enroll in, or receive benefits under, Medicare.

Summary of Health Coverage Eligibility

Given the similarities and differences in the lists/definitions of *lawfully present* and/or who is eligible for the federally funded health care programs discussed above, **Table 1** summarizes noncitizen eligibility for these programs. Noncitizens who are potentially eligible for these programs based on their immigration status must also meet the program's basic eligibility and other requirements.

Table 1. Summary of Noncitizen Eligibility for Selected Health Coverage Programs

Immigration Category	Medicaid/CHIP	ACA Health Insurance Exchanges (HIEs)	Medicare
Adjustment of status applicants	No[a]	Yes	Yes, if a spouse or child of U.S. citizen
Afghan parolees	Yes	Yes	Yes
Asylees	Yes	Yes	Yes
Asylum applicants	No[b]	Yes, if granted work authorization[c]	Yes, if granted work authorization[c]
Certain abused spouses and children	Yes	Yes	Yes
Conditional entrants	Yes	Yes	Yes

[112] Or are under age 14 and have had a pending application for at least 180 days.

[113] Subsequent to the enactment of PRWORA, lawmakers enacted P.L. 106-386. Although this law did not amend PRWORA, it made victims of trafficking eligible for benefits and services "under any Federal or State program" to the same extent as refugees. As a result, victims of trafficking may be eligible for Medicare.

[114] Iraqi and Afghan special immigrants are treated like refugees for purposes of federal public benefits. P.L. 110-181 (as amended) and P.L. 111-8 (Division F, Title IV, as amended) enabled certain Iraqi and Afghan nationals to become eligible for an SIV and qualify for the same federal assistance available to refugees. Consequently, Iraqi and Afghan special immigrants may be eligible for Medicare.

[115] After the elected Afghan government's collapse and Taliban takeover in August 2021, Congress passed P.L. 117-43 (Division C, §2502), which provided certain Afghan parolees with benefits to the same extent as refugees until March 31, 2023, or the end of their parole term, whichever is later. Consequently, these Afghan parolees may be eligible for Medicare.

[116] In response to Russia's renewed invasion of Ukraine in February 2022, Congress passed P.L. 117-128 (Title IV, §401), which provided certain Ukrainian parolees with benefits to the same extent as refugees (with the exception of the initial resettlement program [i.e., the State Department's Reception and Placement Program]) until the end of their parole term. Consequently, these Ukrainian parolees may be eligible for Medicare.

Immigration Category	Medicaid/CHIP	ACA Health Insurance Exchanges (HIEs)	Medicare
Cuban-Haitian entrants	Yes	Yes	Yes
Deferred Action recipients (not including DACA)	No	Yes	Yes
DACA recipients	No	No	Yes[d]
DED recipients	No	Yes	Yes
Family unity beneficiaries	No[e]	Yes	Yes
FAS migrants	Yes	No	Yes[f]
Iraqi and Afghan special immigrants	Yes	Yes	Yes
LPRs	Yes	Yes	Yes
Nonimmigrants	No	Yes	Yes[f]
Refugees	Yes	Yes	Yes
Parolees, granted for at least one year	Yes	Yes	Yes
Parolees, granted for less than one year	No	Yes, with some exceptions[g]	Yes, with some exceptions[h]
Special agricultural workers in temporary resident status	No[i]	Yes	Yes
Special Immigrant Juvenile applicants	No[j]	Yes	No[j]
TPS recipients	No	Yes	Yes
TPS applicants	No	Yes, if granted work authorization	No
Ukrainian parolees	Yes	Yes	Yes
Victims of human trafficking	Yes	Yes	Yes
Withholding of removal grantees (INA)	Yes	Yes	Yes
Withholding of removal applicants (INA)	No	Yes, if granted work authorization[k]	Yes, if granted work authorization[k]
Withholding of removal grantees (CAT)	No	Yes	No[l]
Withholding of removal applicants (CAT)	No	Yes, if granted work authorization[k]	Yes, if granted work authorization[k]
Certain noncitizens who entered the United States before January 1, 1982, in temporary resident status	No[m]	Yes	Yes

Source: Medicaid: 8 U.S.C. §1641; ACA HIEs: 45 C.F.R. §152.2; Medicare: 8 C.F.R. §1.3.

Notes: CHIP=the State Children's Health Insurance Program

a. While adjustment of status applicants are not explicitly mentioned in the laws governing noncitizen eligibility for Medicaid and CHIP, individuals who apply for adjustment of status may be eligible depending on their underlying immigration status/category.
b. While asylum applicants are not explicitly mentioned in the Medicaid/CHIP eligibility laws, individuals who apply for asylum may be eligible depending on their underlying immigration status/category.
c. Or if the applicant is under age 14 and has an application pending for at least 180 days. Asylum applicants may apply for work authorization 150 days after filing their application. Applicants must wait an additional 30 days to receive work authorization, for a total waiting period of 180 days. See CRS Report R45539, *Immigration: U.S. Asylum Policy*.
d. DACA recipients are eligible because individuals with deferred action are eligible. 8 C.F.R. §236.21(c)(3). Unlike the ACA HIEs, Medicare regulations do not except DACA recipients. The average age of DACA recipients as of 2022 is 28; if they are eligible and enrolled in Medicare, it is most likely due to disability status (e.g., being entitled to Social Security disability benefits under certain conditions). Age data from Fwd.us, "DACA Decade: From Students to Careers and Families," June 14, 2022, https://www.fwd.us/news/dacas-beneficiaries-after-10-years/#:~:text=Among%20current%20DACA%20holders%2C%20the,have%20attained%20some%20college%20education.
e. Given that this status was created in 1990 and was a temporary status, as of the cover date of this report, it is likely they would be LPRs or naturalized citizens and would be eligible for Medicaid.
f. Eligibility is based on the category noncitizens who have been "inspected and admitted to the United States and not violated the terms of their admissions." See Social Security Adminstration, *Program Operations Manual System (POMS),* "RS 00204.025 Evidence Requirements for Establishing U.S. Lawful Presence," at https://secure.ssa.gov/poms.nsf/lnx/0300204025.
g. See 45 C.F.R. §152.2(3) for exceptions.
h. See 8 C.F.R. §1.3(a)(3)(i-ii) for exceptions.
i. Given that this status was created in 1986 and was a temporary status that provided a path to LPR status, as of the cover date of this report, it is likely they would be LPRs or naturalized citizens and would be eligible for Medicaid.
j. While SIJ applicants are not explicitly mentioned in the laws governing noncitizen eligibility for these programs, individuals who are applying for SIJ may be eligible depending on their underlying immigration status/category. In addition, individuals under 65 would only be eligible for Medicare due to disability status.
k. Or if the applicant is under age 14 and has an application pending for at least 180 days.
l. CAT grantees are not specified in the lawful-presence definition under 8 C.F.R. §1.3 nor in the Social Security Administration's policy guidance on establishing lawful presence.
m. This refers to noncitizens who were able to adjust to LPR status, pursuant to the Immigration Reform and Control Act of 1986 (IRCA; P.L. 99-603). As of the cover date of this report, it is likely they would be LPRs or naturalized citizens and would be eligible for Medicaid/CHIP.

Health Care Settings and Public Health Services

While federal law excludes non-qualified aliens (see the "Qualified Alien" section above) from many types of federal health insurance coverage, they may be able to receive some health services supported through federal grant programs. Certain programs discussed below provide support to entities that provide care to all individuals regardless of ability to pay. Other programs support public health services that would meet the exception included in PRWORA for prevention, testing, and treatment of communicable diseases. Specifically, PRWORA makes an exception from the general exclusion of immigrants from public programs that provide health services "for immunizations with respect to immunizable diseases and for testing and treatment of symptoms of communicable diseases whether or not such symptoms are caused by a communicable disease."[117] Therefore, any noncitizen, regardless of immigration status, can

[117] 8 U.S.C. §1611(b)(1)(C). For purposes of COVID-19 testing and vaccination, these services were available regardless of immigration status. For further discussion, see CRS Report R46481, *COVID-19 Testing: Frequently Asked Questions*; and CRS Insight IN11617, *Unauthorized Immigrants' Access to COVID-19 Vaccines*.

receive these types of public health assistance. In some cases, these services may be available through programs that receive federal grants, as discussed below.

As noted previously, some health care settings provide care to individuals regardless of their ability to pay. These settings may be a source of care for immigrant populations who lack access to third-party coverage. Generally, in these settings program requirements to provide care involve delivering services without regard for the patient's ability to pay and do not explicitly discuss immigration status. Settings that provide care to all regardless of their ability to pay are generally termed *the health care safety net*.[118] Some individual health care providers (e.g., physician practices) may provide care for all regardless of their ability to pay, but they are not required to do so. However, certain facilities are required to provide care and are the more common safety net providers. These include emergency departments, some hospital charity-care programs, health centers, and free clinics. Some providers such as health departments and Ryan White HIV/AIDS clinics also provide limited services to individuals regardless of their ability to pay. The health settings discussed below vary in the services provided and may charge for services; the key feature is that settings cannot deny services for lack of ability to pay or insurance status, either under federal law and policy or under the organization's policy.

Hospital Emergency Departments

The federal government requires—as a condition of Medicare participation—that hospitals with dedicated emergency departments (EDs) screen and provide stabilizing treatment and certain other care to patients with emergency conditions regardless of a patient's ability to pay[119]; therefore, they may be a source of care for uninsured individuals, including immigrants. This requirement is set forth in the Emergency Medical Treatment and Active Labor Act (EMTALA), which was enacted in 1986 as part of the Consolidated Omnibus Budget Reconciliation Act of 1985 (P.L. 99-272). EMTALA was enacted in response to controversies that arose when patients died because some hospitals refused emergency services to uninsured patients as a way of reducing the amount of uncompensated care they provided (a practice known as *dumping*).[120]

EMTALA requires that patients be medically evaluated—through an appropriate medical screening exam—to determine whether an emergency medical condition exists. If it is determined that such a condition exists, the ED is required to provide stabilizing treatment. Once the patient is stabilized, the patient may be transferred to another hospital that has the capability to provide the needed level of care if the patient's condition requires care that the hospital from which they received stabilizing care cannot provide. EMTALA does permit hospitals to bill patients for services; as such, it is not necessarily a source of free care.

Hospital Charity Care Programs

Hospitals may provide free or discounted care as determined by the hospital's financial assistance policy (FAP)—commonly referred to as *charity care*. Further, hospitals that seek or maintain

[118] HHS, Agency for Healthcare Research and Quality, "Topic: Safety Net," https://www.ahrq.gov/topics/safety-net.html. Medicaid is an important payer for safety-net populations; this section discusses health care delivery settings, which is a different issue from how these services are paid for.

[119] Hospital-based EDs are required to provide care per EMTALA; however, the act only refers to stabilizing procedures and not to all services available within an ED or a hospital in general. Some hospitals provide necessary treatment as dictated and transfer patients to other facilities for a variety of reasons: insurance, specialty needs, patient request, or bed availability.

[120] Mark M. Moy, *The EMTALA Answer Book: 2009 Edition* (Wolters Kluwer Law & Business, 2009), p. xxxiv.

federal tax-exempt status must meet a *community benefit standard*.[121] Some states impose similar standards for state tax exemptions or as requirements imposed on nonprofit (and in some cases, for-profit) hospitals.[122] In general, hospitals must demonstrate that they meet the community benefit standard by providing charity care or by engaging in other health promotion activities.[123] Tax-exempt hospitals are also *required* to have a written FAP under federal law, and a similar requirement is imposed under some state laws on nonprofit (and in some cases, for-profit) hospitals.[124] FAPs vary by hospital. In general, policies take into account the patient's income, and thus may be a source of uncompensated or reduced cost care for immigrant populations.

Beyond tax requirements related to charity care, hospitals may also receive Medicare uncompensated care payments.[125] These payments offset some of a hospital's uncompensated care costs, including charity care.[126]

Health Centers

Health centers—also referred to as federally qualified health centers—are federally funded outpatient facilities that provide primary care, dental care, and some behavioral health services. They are required to be located in medically underserved areas and must provide care to all regardless of their ability to pay. These facilities receive grants, as authorized under Section 330 of the Public Health Service Act (PHSA, 42 U.S.C. § 254b), and are required to establish a sliding scale fee schedule that is applicable to patients who do not have insurance and have incomes below 200% of the federal poverty level. In 2021, there were more than 14,000 health center delivery sites throughout the United States; nearly one-fifth of the more than 28 million patients served did not have health insurance.[127] There are four types of health centers: community health centers, health centers for migrant workers, health centers for the homeless, and health centers for residents of public housing.[128] Immigrants can be served at all four types of health centers. Health centers are required to have referral arrangements for after-hours care, and refer patients to specialists for care they do not provide. These specialty providers are not governed by the grant requirements to provide sliding scale fees, so they may charge for services (or not accept uninsured patients). As such, research has found that uninsured health center patients face barriers when attempting to access specialty services that health centers do not provide.[129]

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[121] 58% of hospitals are tax-exempt. See Zachary Levinson, Scott Hulver, and Tricia Neuman, *Hospital Charity Care: How It Works and Why It Matters*, *Kaiser Family Foundation*, November 2022. For information on federal community benefit standards, see CRS Report RL34605, *501(c)(3) Hospitals and the Community Benefit Standard*.

[122] The HillTop Institute, University of Maryland, Baltimore Campus (UMBC), *Community Benefit State Law Profiles Comparison*, Baltimore, MD, https://hilltopinstitute.org/our-work/hospital-community-benefit/hcbp-state-comparison/.

[123] For information on federal requirements, see CRS Report RL34605, *501(c)(3) Hospitals and the Community Benefit Standard*. For state information, see The HillTop Institute, UMBC, *Community Benefit State Law Profiles Comparison*, Baltimore, MD, https://hilltopinstitute.org/our-work/hospital-community-benefit/hcbp-state-comparison/.

[124] For more information, see CRS Report RL34605, *501(c)(3) Hospitals and the Community Benefit Standard*.

[125] Medicare uncompensated care payments are not limited to tax-exempt hospitals. Tax-exempt and for-profit hospitals (i.e., not tax-exempt) provide uncompensated care and receive Medicare uncompensated care payments.

[126] For more information, see CRS In Focus IF10918, *Hospital Charity Care and Related Reporting Requirements Under Medicare and the Internal Revenue Code*.

[127] HHS, Health Resources and Services Administration (HRSA), *Justification of Estimates for Appropriations Committees, FY2023*, https://www.hrsa.gov/sites/default/files/hrsa/about/budget/budget-justification-fy2023.pdf, pp. 70-71.

[128] For more information, see CRS Report R43937, *Federal Health Centers: An Overview*.

[129] Mabel C. Ezeonwu, "Specialty-Care Access for Community Health Clinic Patients; Processes and Barriers,"

Health centers collect data on the population they serve by a number of characteristics, including age, race/ethnicity, insurance status, and whether patients are best served in a language other than English. Health centers report that nearly one-quarter of the patients they serve are best served in a language other than English.[130] Health centers do not collect data on their service population's immigration status. This is likely because the goal of health centers is to provide care to all and collecting such data may deter individuals from seeking care.

Free Clinics

There are more than 1,400 free clinics that provide care at free or reduced rates.[131] The services provided vary by clinic. Primary care services are the most common services they provide, followed by referrals and lab services.[132] The federal government does not provide direct support for these facilities. As such, it does not require that free clinics provide a specific set of services.[133] The National Association of Free & Charitable Clinics provides some data on free clinics in 2020. It found that free clinics served 1.7 million patients, who had 5.7 million patient visits. It also reported that 85% of the patients served were uninsured, but it did not report data on immigration status.[134]

Selected Public Health Programs and Limited Health Service Providers

Some publicly funded health providers offer a limited set of services to all individuals regardless of their ability to pay. These include programs to provide family planning services, Human Immunodeficiency Virus (HIV) or Acquired Immune Deficiency Syndrome (AIDS) care, and funding to public health departments that may provide health services (e.g., screenings) and vaccinations.

Title X Family Planning Program

The Department of Health and Human Services' (HHS') Title X program provides grants to public and nonprofit agencies to provide family planning services to individuals regardless of

Journal of Multidisciplinary Healthcare, vol. 11 (February 22, 2018), pp. 109-119.

[130] HHS, HRSA, "Health Centers Program Uniform Data System (UDS) Data Overview, Table 3B: Patients by Race and Hispanic or Latino/a Ethnicity" https://data.hrsa.gov/tools/data-reporting/program-data/national/table?tableName=3B&year=2021.

[131] The National Association of Free & Charitable Clinics: "National Association of Free & Charitable Clinics," https://nafcclinics.org/.

[132] The National Association of Free & Charitable Clinics: "A Look at U.S. Free and Charitable Clinics and Pharmacies-2021," https://nafcclinics.org/wp-content/uploads/2021/10/NAFC-2021-Infographic.pdf.

[133] Free clinic employees and contractors may receive medical malpractice coverage through the federal government through the Free Clinics Medical Malpractice Program. This is in-kind support and requires that a facility be licensed and that it not accept third-party reimbursements (i.e., insurance); these facilities may not charge patients for services. See HHS, HRSA, *Justification of Estimates for Appropriations Committees, FY2023*, https://www.hrsa.gov/sites/default/files/hrsa/about/budget/budget-justification-fy2023.pdf, pp. 84-86. 220 free clinics participate in this program. Free clinics that provide services using a sliding scale fee schedule are not eligible, which may explain why a larger number of free clinics are counted on the national association's website; see https://nafcclinics.org/.

[134] The National Association of Free & Charitable Clinics: "A Look at U.S. Free and Charitable Clinics and Pharmacies-2021," https://nafcclinics.org/wp-content/uploads/2021/10/NAFC-2021-Infographic.pdf.

their ability to pay.[135] Facilities use a sliding scale fee schedule.[136] Services available are those related to contraception (including counseling) and screening and treatment for sexually transmitted infections or disease (STI/STD).

Ryan White HIV/AIDS Program

The federally funded Ryan White HIV/AIDS program provides medical services to individuals with HIV/AIDS. With some exceptions, individuals must have either HIV or AIDS to be eligible. Services provided include outpatient and ambulatory medical care, pharmaceuticals related to HIV/AIDS, substance abuse services, and other services related to treating individuals with AIDS (e.g., hospice and home health services).[137] Ryan White program services are part of the general health care safety net; grant funds must be used only when the Ryan White program client does not have an alternate source of payment (i.e., public or private insurance). When determining eligibility for the Ryan White program and for payment for services from grant funds, the program considers the individual's HIV status and income; it does not use immigration status in this determination.[138] The goal of the program is to connect individuals with HIV or AIDS to treatment. In addition, under the *Ending the HIV Epidemic Initiative*, 57 priority state and local jurisdictions with substantial HIV burden have received additional funding for HIV testing, preventive treatments, and other prevention services.[139]

Centers for Disease Control and Prevention (CDC) Programs and Health Services Through Public Health Departments

Another potential source of care for noncitizens is through HHS' Centers for Disease Control and Prevention (CDC)-funded public health programs administered by state, local, tribal, and territorial health departments. State and territorial public health departments administer CDC grants and programs that fund preventive health services targeted at low-income and uninsured individuals, including the following (among others):

- The Vaccines for Children Program, as authorized in Social Security Act (SSA) Section 1928;

[135] While Title X does not explicitly note its immigration policies, the National Family Planning & Reproductive Health Association notes that the program provides services regardless of immigration status. National Family Planning & Reproductive Health Association, *Title X: key Facts About Title X*, Washington, DC, https://www.nationalfamilyplanning.org/title-x_title-x-key-facts. Other researchers have found that immigrant women are more likely to use safety net family planning centers for contraceptive care than are U.S.-born women. This would include, but not be exclusive to, Title X services. See Kinsey Hasstedt, Sheila Desai, and Zohra Ansari-Thomas, *Immigrant Women's Access to Sexual and Reproductive Health Coverage and Care in the United States*, The Commonwealth Fund, issue briefs, New York, NY, November 20, 2018, https://www.commonwealthfund.org/publications/issue-briefs/2018/nov/immigrant-womens-access-sexual-reproductive-health-coverage.

[136] For more information, see CRS In Focus IF10051, *Title X Family Planning Program*.

[137] For more information, see CRS Report R44282, *The Ryan White HIV/AIDS Program: Overview and Impact of the Affordable Care Act*.

[138] HHS, HRSA, HIV AIDS Bureau, *Determining Client Eligibility & Payor of Last Resort in the Ryan White HIV/AIDS Program*, Policy Clarification Notice 21-02, Rockville, MD, October 21, 2021, https://ryanwhite.hrsa.gov/sites/default/files/ryanwhite/grants/pcn-21-02-determining-eligibility-polr.pdf.

[139] HHS, "Ending the HIV Epidemic: A Plan for America," 2019, https://files.hiv.gov/s3fs-public/Ending-the-HIV-Epidemic-Counties-and-Territories.pdf; and HHS, "HHS Agencies Involved in the Ending the HIV Epidemic," https://www.hiv.gov/federal-response/ending-the-hiv-epidemic/federal-action/agencies.

- The Immunization Cooperative Agreement program, as authorized by PHSA Section 317 and SSA Section 1928, which provides funding to states, territories, and selected local jurisdictions that can be used to purchase vaccines for uninsured or underinsured populations;
- The National Breast and Cervical Cancer Early Detection Program, as authorized in PHSA Section 1501[140]; and
- The WISEWOMAN (Well-Integrated Screening and Evaluation for WOMen Across the Nation) program, which provides heart disease and stroke risk factor screenings.

In addition, several CDC grants fund testing and screening services for HIV and other STIs.[141]

State health departments may work with private health care facilities, nonprofit organizations, or local health departments to provide CDC-funded services to residents. Local public health departments often vary in the services they provide, and they may have varying policies in terms of immigrants' access to certain services due to their immigration status. Some public health departments may charge the individual or their insurance for certain services they provide. A 2019 survey of local health departments found that 88% reported providing childhood and adult immunizations, nearly two-thirds provided screening for sexually transmitted diseases, and 62% provided HIV/AIDS testing. Smaller percentages of local health departments provided health services such as treatment for communicable diseases, well-child clinics, and prenatal care.[142]

Barriers to Access: Immigration-Related Fears

Immigrant populations may still face barriers when accessing health care despite their eligibility and the availability of some of the programs and services discussed above. Some barriers are similar for low-income and uninsured populations more generally. These include barriers related to the cost of services, lack of transportation, and lack of sick leave or unpredictable work schedules that make it difficult to schedule or keep medical appointments and obtain follow up care.[143] These barriers affect many immigrants as well, and are in addition to specific concerns among this population that are related to their immigration status. This section discusses a few of these potential barriers.

[140] See also the description in the "What is the National Breast and Cervical Cancer Early Detection Program?" section of CRS Report R46785, *Federal Support for Reproductive Health Services: Frequently Asked Questions*.

[141] See HHS, CDC, "HIV Funding and Budget," https://www.cdc.gov/hiv/funding/index.html; and the section on "HIV/AIDS, Viral Hepatitis, Sexually Transmitted Infections, and Tuberculosis" in HHS, CDC, *FY2023 Congressional Budget Justification*, pp. 93-125. See also the description in the "What Centers for Disease Control and Prevention (CDC) Programs Address STIs?" section of CRS Report R46785, *Federal Support for Reproductive Health Services: Frequently Asked Questions*.

[142] National Association of County and City Health Officials, *2019 National Profile of Local Health Departments*, Chapter 7, "Programs and Services," https://www.naccho.org/uploads/downloadable-resources/Programs/Public-Health-Infrastructure/NACCHO_2019_Profile_final.pdf,.

[143] Corrinne Lewis, Melinda K. Abrams, and Shanoor Seervai, *Listening to Low-Income Patients: Obstacles to the Care We Need, When We Need It*, The Commonwealth Fund, Improving Health Care Quality, blog, New York, NY, December 1, 2017, https://www.commonwealthfund.org/blog/2017/listening-low-income-patients-obstacles-care-we-need-when-we-need-it.

Immigration Enforcement Fears

Certain immigrants may be hesitant to seek medical care because of fears about immigration enforcement, such as being arrested at a health care center. However, Immigration and Customs Enforcement (ICE) has a long-standing policy of not taking enforcement actions (e.g., arrests, interviews, searches) at certain "sensitive locations,"[144] which include medical treatment and health care facilities.[145] Nevertheless, studies have shown that fear of deportation or immigration enforcement actions are a barrier to unauthorized immigrants' utilization of health care for which they may be eligible.[146]

Effect of the Public Charge Rule

Under the INA, a noncitizen may be denied admission into the United States or LPR status if he or she is "likely at any time to become a public charge" (8 U.S.C. §1182(a)(4)).[147] The INA does not define the term *public charge*.[148] Thus, the determination of whether an alien is inadmissible[149] on public charge grounds turns largely on standards set forth in agency guidance.[150]

From 1999 to 2019, agency guidance[151] defined *public charge* to mean a person who is or is likely to become primarily dependent on public cash assistance or government-funded institutionalization for long-term care.[152] This definition was changed on August 15, 2019, when DHS published a final rule that expanded the list of public benefits considered in public charge determinations to include nine programs, including Medicaid.

There were multiple lawsuits challenging the 2019 public charge final rule, and DHS decided not to defend the rule on appeal.[153] Thus, on March 9, 2021, the agency reverted back to the 1999

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[144] Immigration and Customs Enforcement (ICE), *FAQS: Protected Areas and Courthouse Arrests*, https://www.ice.gov/about-ice/ero/protected-areas; and ICE, *Enforcement Actions at or Focused on Sensitive Locations*, https://www.ice.gov/doclib/ero-outreach/pdf/10029.2-policy.pdf.

[145] For example, see Scott D. Rhodes et al., "The Impact of Local Immigration Enforcement Policies on the Health of Immigrant Hispanics/Latinos in the United States," *American Journal of Public Health*, vol. 105, no. 2 (February 2015), pp. 329-337.

[146] Karen Hacker et al., "Barriers to Health Care for Undocumented Immigrants: A Literature Review," *Risk Management and Healthcare Policy* , vol. 8 (2015), pp. 175-183; and Medha D. Makhlouf, "Health Care Sanctuaries," *Yale Journal of Health Policy, Law, and Ethics*, vol. 20, no. 1 (2021), pp. 3-67, https://yaleconnect.yale.edu/get_file?pid=24b1516cab2e22b5db84943fa275233a139d5a92ea48b562ee3a0a932a69ce98

[147] An admitted alien may also be subject to removal from the United States based on a separate public charge ground of deportability, but this is rarely employed.

[148] For more information on the current public charge rule, see CRS Insight IN11217, *Immigration: Public Charge 2022 Final Rule*. For more information on the 2019 public charge rule, see CRS In Focus IF11467, *Immigration: Public Charge*.

[149] "Aliens who are inadmissible ... are ineligible to receive visas and ineligible to be admitted to the United States" (8 U.S.C. §1182). A noncitizen can be deemed inadmissible for health, security, public charge, and criminal-related grounds, among others.

[150] DHS and the Department of State have primary responsibility for implementing the public charge ground of inadmissibility.

[151] This includes guidance from what was formerly the Department of Justice's Immigration and Naturalization Service (INS), which is now a part of DHS. DHS, established in 2002, includes the agencies that are currently responsible for most federal immigration functions.

[152] DOJ, INS, "Field Guidance on Deportability and Inadmissibility on Public Charge Grounds," 64 *Federal Register* 28689, March 26, 1999, at https://www.govinfo.gov/content/pkg/FR-1999-05-26/pdf/99-13202.pdf.

[153] For more information, see DHS, USCIS, "Inadmissibility on Public Charge Grounds Final Rule: Litigation," at

definition. In September 2022, DHS published a final rule that codified in the *Code of Federal Regulations* a definition of the phrase, "likely at any time to become a public charge" based largely on a standard similar to the 1999 guidance.[154]

While the 2019 rule was in effect, it appears to have had an effect on immigrants' use of public benefits, including health care services.[155] Many observers were concerned that this rule led some immigrants to not use public benefits even though they were not subject to the public charge rule (e.g., LPRs, U.S. citizen children of immigrants).[156] Such effects appear to have deterred enrollment of eligible people in benefit programs. Some observers contend these effects could take time to reverse even though the policy has changed.[157]

https://www.uscis.gov/green-card/green-card-processes-and-procedures/public-charge/inadmissibility-on-public-charge-grounds-final-rule-litigation.

[154] DHS, "Public Charge Ground of Inadmissibility," 87 *Federal Register* 55472, September 9, 2022. For more information, see CRS Insight IN11217, *Immigration: Public Charge 2022 Final Rule*.

[155] Hamutal Bernstein et al., *Immigrant Families Continued Avoiding the Safety Net during the COVID-19 Crisis, Urban Institute*, https://www.urban.org/research/publication/immigrant-families-continued-avoiding-safety-net-during-covid-19-crisis; and Jennifer Tolbert et al., *Impact of Shifting Immigration Policy on Medicaid Enrollment and Utilization of Care among Health Center Patients, Kaiser Family Foundation*, https://www.kff.org/medicaid/issue-brief/impact-of-shifting-immigration-policy-on-medicaid-enrollment-and-utilization-of-care-among-health-center-patients/.

[156] Hamutal Bernstein et al., *Amid Confusion of the Public Charge Rule, Immigrant families Continued Avoiding Public Benefits in 2019, Urban Institute*, https://www.urban.org/sites/default/files/publication/102221/amid-confusion-over-the-public-charge-rule-immigrant-families-continued-avoiding-public-benefits-in-2019_3.pdf; and Jennifer Tolbert et al., *Impact of Shifting Immigration Policy on Medicaid Enrollment and Utilization of Care among Health Center Patients*, Kaiser Family Foundation, https://www.kff.org/medicaid/issue-brief/impact-of-shifting-immigration-policy-on-medicaid-enrollment-and-utilization-of-care-among-health-center-patients/.

[157] Caroline LaRochelle, *Thawing the Chill from Public Charge Will Take Time and Investment*, Children's Hospital of Philadelphia PolicyLab, Philadelphia, PA, April 13, 2021, https://policylab.chop.edu/blog/thawing-chill-public-charge-will-take-time-and-investment#:~:text=This%20phenomenon%20of%20not%20enrolling,programs%20written%20into%20the%20rule.

Appendix. Acronyms Used in this Report

Table A-1. Acronyms

Acronym	Definition
ACA	Affordable Care Act
AIDS	Acquired Immune Deficiency Syndrome
CAT	Convention Against Torture
CDC	Centers for Disease Control and Prevention
CHIP	State Children's Health Insurance Program
COFA	Compacts of Free Association
DACA	Deferred Action for Childhood Arrivals
DED	Deferred Enforced Departure
DHS	Department of Homeland Security
ED	Emergency Department
EMTALA	Emergency Medical Treatment and Active Labor Act
FAS	Freely Associated States
FAP	Financial Assistance Policy
FMTPB	Federal Means-tested Public Benefits
HHS	Health and Human Services
HIE	Health Insurance Exchanges
HIV	Human Immunodeficiency Virus
ICE	Immigration and Customs Enforcement
INA	Immigration and Nationality Act
IRCA	Immigration Reform and Control Act of 1986
LPR	Lawful Permanent Residents
NASEM	National Academies of Sciences, Engineering, and Medicine
PHSA	Public Health Service Act
PTC	Premium Tax Credits
PRWORA	Personal Responsibility and Work Opportunity Reconciliation Act of 1996
SIJ	Special Immigrant Juveniles
SIV	Special Immigrant Visa
TPS	Temporary Protected Status
USCIS	U.S. Citizenship and Immigration Services
VAWA	Violence Against Women Act

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