

EXPANDING HEALTH CARE ACCESS TO ALL THROUGH STATE LAW



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Introduction

Ensuring that people with undocumented status have access to health care insurance is important for racial and health equity. Federal law excludes people who are undocumented immigrants from accessing most federally funded public health insurance programs. To address this gap, many states are enacting laws to expand access to comprehensive, affordable health insurance for undocumented immigrants based on income guidelines, using state funds or other means. This policy brief describes the racist and xenophobic roots of current policies that exclude undocumented immigrants from access to health care insurance and other public benefits, and summarizes the current health insurance policy landscape. The report then discusses the racial and health equity-centered rationales for legislative action and provides guidance on state policy mechanisms for extending access to health care, including limitations and recommendations.

1. Background Data on Immigrants and Health Care Access in the U.S.

Immigrant populations in the U.S. are diverse, varying greatly in country of origin, demographics, incomes, employment types, reasons for residing in the U.S., immigration status, and health outcomes. In 2020, there were about 44.8 million immigrants living in the U.S., including about 22.7 million naturalized citizens and 22.1 million noncitizens, each accounting for about 7% of the total U.S. population.¹ Most noncitizens have legal, or documented, immigration status; however, about 40% of noncitizens are undocumented.² About 60% of all undocumented immigrants in the U.S. live in six states (CA, TX, FL, NY, NJ, and IL).³

U.S. Census Bureau and other national data tabulated by the Migration Policy Institute indicates that about two-thirds (67%) of undocumented immigrants in the U.S. are from Mexico and Central America; 15% from Asian countries; 8% from South American countries; 4% from Europe, Canada, or Oceania; 3% from the Caribbean; and 3% from African nations.⁴ Mexico is the primary country of origin for immigrants residing in the U.S., accounting for about 25% of all immigrants and 48% of undocumented immigrants nationally; in some states, these percentages are significantly higher or lower.⁵ Many undocumented immigrant residents encounter the xenophobia and racism that Indigenous, Black, Latine, Asian American/Pacific Islander (AAPI), and other Black and Brown peoples (also referred to as people of color)*

* For this document, we have used the collective labels listed here as much as possible when referring to various political, racial, and ethnic groups. We occasionally have used alternative labels when appropriate, based on terminology used in source material, such as cited research reports, quotes, terminology used in a particular jurisdiction's materials, etc. We recognize that the language of equity is constantly evolving and no one label can capture the complexities of racial and ethnic identities. We also understand that there may be political implications regarding the use of labels. We do not wish to perpetuate insensitivity associated with any of these labels; as such, we recommend that labels preferred by community members in the specific community or region be used whenever possible.

experience in the U.S., while also having to navigate the considerable challenges of being undocumented.

For families, immigration and documentation status can be critical factors for health outcomes. About one quarter (25.9%) of children in the U.S. have an immigrant parent.⁶ Although more than 90% of these children are U.S. citizens, over 60% of them have noncitizen parents.⁷ This reflects the reality that immigrant families in the U.S. often consist of a mix of citizens and noncitizens, including documented and undocumented family members. Family members' immigration status can have profound consequences for both individual and family access to health care coverage, eligibility for health care services, and when, where, and how family members can receive care. For example, noncitizens, including undocumented immigrants and citizen children of undocumented parents, are considerably more likely to be uninsured compared to citizens.⁸ In 2020, among nonelderly people, about 42% of undocumented immigrants were uninsured compared to about 26% of lawfully present immigrants and 8% of citizens.⁹ Disparities in access to health insurance coverage affect citizen children with noncitizen parents as well as noncitizen children. Citizen children who have at least one noncitizen parent are much less likely to be insured compared to children with citizen parents (10% vs. 4%).¹⁰

2. Structural Inequities in Access to Health Care & Structural Responses

Structural racism and xenophobia are root causes of noncitizen immigrant residents' lack of access to comprehensive health care coverage and services in the U.S. As the statistics above reflect, undocumented immigrants are acutely affected by these inequities.¹¹ Structural racism shows up in federal, state, and local health laws and policies through inequitable distributions of resources in ways that empower, value, and advantage white people while disempowering, devaluing, and disadvantaging people of color.

U.S. immigration laws provide a clear-cut example of structural racism. The Chinese Exclusion Act of 1882 was the first law to restrict immigration to the U.S. As its name states, this law specifically barred Chinese people from immigrating to the U.S. based on fabricated concerns that Chinese workers were causing high unemployment rates for white workers.¹² This law and the court opinions it generated laid the groundwork for the development of a system of immigration laws in the U.S. that methodically privileges white, heterosexual, able-bodied people with financial means and continues to systematically disadvantage people from nations outside of northern Europe.¹³ Another well-established and highly relevant example of

institutionalized structural racism in the U.S. is the nation's health care delivery system, which has allowed patterns, practices, and procedures to marginalize and exploit racial, ethnic, and cultural communities who are not white. Numerous studies and reports have demonstrated that inequities in access to coverage and in the U.S. health care delivery system contribute to people of color experiencing disproportionately negative health outcomes compared to white people.¹⁴

Many factors contribute to inequities experienced by undocumented immigrants with regard to access to health care coverage and services. These factors include racism and other forms of discrimination which result in undocumented people being concentrated in jobs in low wage industries such as hospitality, service, agriculture, and maintenance, which often lack health insurance benefits, paid leave, and other work benefits; lack of safe, affordable housing; challenges in access to transportation and healthy food; lack of linguistically and culturally-appropriate services; and laws and systems that deny undocumented immigrants access to health care coverage and services—the focus of this report.

Undocumented immigrants also grapple with concern and fear about actual or perceived adverse legal consequences related to seeking health care coverage or other public benefits, including fear of being deported or denied lawful permanent residency status (e.g., if categorized as a “public charge”).¹⁵ Another contributing factor is immigrants' lack of access to information about available health care options due, in part, to institutions' insufficient outreach efforts and failure to address language barriers, literacy, and health literacy needs.

COVID-19 has laid bare ways in which structural inequities have increased risks of exposure to the virus and negative health outcomes for undocumented immigrants compared to U.S. citizens.¹⁶ Notably, during the pandemic about seven million undocumented immigrants helped lift up major sectors of the workforce, including five million undocumented individuals employed as front-line essential workers (e.g., farmers, construction laborers, custodial staff, and health aides).¹⁷ High rates of uninsurance, combined with fear of legal repercussions among immigrant populations, has led many immigrants to forego testing and treatment even when these options are freely available, compounding COVID-19's devastating impact.¹⁸ These circumstances have had severe and heartbreaking impacts on many immigrant families and demonstrate the extreme harm of the underlying inequities.¹⁹

Beyond COVID-19-related impacts, excluding undocumented immigrants from eligibility for health care coverage contributes in other ways toward increases in infectious disease rates.²⁰ For example, undocumented people fearing immigration enforcement may delay seeking care for infectious diseases such as tuberculosis, threatening both individual and public health.²¹ As another example, undocumented immigrants with end-stage kidney disease who depend



on emergency dialysis due to their immigration status have been shown to have higher rates of unexpected death due to cardiac arrhythmias.²² Inequities such as these have led the American Public Health Association to declare exclusionary immigration policies harmful to undocumented immigrants' health.²³

Similarly, leading medical professional societies including the American Medical Association, American College of Physicians, the American Academy of Family Physicians, and the American Nurses Association have taken the position that all individuals living in the United States, regardless of their immigration status, should be granted access to quality health care, including the opportunity to purchase insurance.²⁴ These national public health experts emphasize that providing undocumented immigrant populations with access to health insurance coverage is an evidence-based approach for reducing health care costs.²⁵ Access to affordable health care coverage for immigrant populations in the U.S. is vital to advancing health equity and reducing health disparities.

The U.S. system of restricting and denying health care services to undocumented immigrants is based on a series of policy decisions that require policy responses. The impact and

consequences of policies that restrict undocumented immigrants from accessing public programs or program components (e.g., Medicaid, Medicare, and private insurance coverage through the Affordable Care Act Marketplace) cannot be overstated. Although some programs may serve a limited, vulnerable subset of undocumented immigrants (such as infants, pregnant people, or people seeking emergency treatment at a hospital), fewer programs and resources exist for sick, nonpregnant adults.²⁶ Some undocumented immigrants rely on Federally Qualified Health Centers (FQHCs) – community health centers that receive federal grant funding to support the uninsured, regardless of immigration status. Nationally, about 1,200 FQHCs provide primary health care, dental, mental health, and pharmacy services to undocumented immigrants on a sliding scale basis. Low-cost and free community clinics also provide care, relying on volunteers and private donations to provide services to those unable to pay.²⁷ Although facilities such as these play crucial roles in our health care safety net system, there are far too few of them and they lack the resources necessary to meet the massive level of unmet needs.

Access to affordable, comprehensive health insurance coverage and health care for undocumented immigrant populations in the U.S. is critical to advancing health equity and reducing health disparities. In recent years, as COVID-19 continued to surge, many states and localities have sought to find ways to cover the remaining uninsured and provide access to health care. To cover low-income residents who are ineligible for subsidized health insurance under the Affordable Care Act (ACA) or through Medicaid or the Children’s Health Insurance Program (CHIP),** states have pursued legislative or administrative actions to extend affordable health care coverage to all residents, regardless of immigration status, using state-only funds or through seeking waivers under the ACA. These approaches have gained traction in recent years – they build on work that established these types of programs before the pandemic, seeing them as an effective public health strategy to address longstanding social, economic, and health inequities.

This report draws on the experiences of 14 states, plus the District of Columbia, that have enacted laws to extend access to health care coverage and services to undocumented immigrants. These advancements provide meaningful examples and learning for other states exploring opportunities for policy change. Highlights from many of these state laws are shared below and in the appendices to this report.

** Federal CHIP funds can be used to provide prenatal care, regardless of immigration status.

3. Spotlight on Minnesota – Undocumented Immigrant Demographics & Policy Landscape

Minnesota’s immigrant population demographics reflect national trends: Immigrants from Mexico represent the single largest population of immigrants in the state, followed by immigrants from African and Southeast Asian countries. Many immigrant households in Minnesota include family members with citizen and noncitizen status.

Demographics

Minnesota has a sizeable immigrant population – totaling nearly half a million. Even so, the proportion of immigrants is smaller than it was a century ago. According to the Minnesota State Demographic Center, in 1920, about one in five Minnesotans was foreign-born whereas, in 2017, about one in 12 were foreign-born (8.2%, or about 448,397).²⁸ Minnesota Compass (a project of Wilder Research) puts the estimate at 8.39%, or about 470,000 of Minnesota’s total population of 5.6 million.²⁹ The variation in these estimates could be attributed to language barriers and trust issues that can result in reduced response rates to Census surveys and under counting of the state’s immigrant population.³⁰

Similar to the national landscape, in 2018, the largest group of foreign-born residents in Minnesota were from Mexico (64,500), followed by Somalia (33,500); India (30,200); Ethiopia (21,900); Laos, including Hmong (24,400); Vietnam (18,600); mainland China (18,600); and Thailand, including Hmong (18,500).³¹ These counts exclude U.S.-born children citizens. In 2018, 11.7% of Minnesotans (age 5+) spoke a language other than English at home.³² The number of Mexican immigrants has declined over the past decade; however, Spanish remains the most common non-English language spoken in the state, followed by Cushitic languages (e.g., Somali and Beja), Hmong, and Vietnamese.³³

Minnesota’s immigrant population varies substantially in number and percentage between the Twin Cities area and greater Minnesota. The foreign-born share of the Twin Cities population increased from 10.3% to 12.6% between 2000 and 2021, whereas the share of immigrants in greater Minnesota increased only slightly – less than 1% (from about 3.1% to 3.9%) during that same period.³⁴ Population growth has been occurring faster in the central part of the state than in other regions.³⁵ About 38% of Mexican Minnesotans live outside the Twin Cities.³⁶ About 94% of Hmong Minnesotans live in the Twin Cities metropolitan area.³⁷

- According to the American Immigration Council, undocumented immigrants accounted for about 2% (about 95,000) of all Minnesotans in 2016, representing about 20% of the state’s total immigrant population.³⁸

- About 138,664 Minnesotans, including 64,136 with citizenship status, lived in mixed-status households with at least one undocumented household member between 2010 and 2014.³⁹ Approximately 4% of Minnesota children (about 48, 292) lived with at least one undocumented family member during that same period.⁴⁰
- Also relevant are recent (2015) statistics showing that the majority of undocumented immigrants in Minnesota speak English well or very well (59%); have a high school degree or higher (55%); are under 35 (62%); and have lived in the U.S. more than five years (77%).⁴¹

Contributions to Minnesota's Economic Vitality

Immigrants are valuable contributors to Minnesota's economic well-being. They play a vital role in the state's labor force, representing at least 11% of all workers and contributing to several major industries including (listed in descending order based on percentage): administrative support, waste management, and remediation services; manufacturing; transportation and warehousing; hospitality (accommodations and food services); and health care and social assistance.⁴² Many of the state's key industries including agriculture, health care, and food manufacturing would be less successful without immigrant workers.⁴³ In sum, immigrant workers do indeed get the job done—their contributions are integral to numerous industries and occupations.⁴⁴ Notably, about 75% of all immigrants in Minnesota participate in the workforce.⁴⁵

- Undocumented immigrant workers represented 2% of the state's workforce in 2016.⁴⁶
- Undocumented immigrants paid about \$191.2 million in federal taxes and \$108.8 million in state and local taxes in 2018.⁴⁷

Immigrants also contribute significantly to the vitality of consumer activity in Minnesota, adding billions to the state's economy every year. In 2018 alone, Minnesota residents in immigrant-led household accounted for \$11.2 billion in spending power (after-tax income).⁴⁸

A 2021 [report](#)⁴⁹ by the Minnesota Chamber Foundation about immigrants' economic contributions to Minnesota concludes that while immigrants often have high levels of poverty upon arrival, they join the workforce, gain an economic foothold, and achieve economic success over time, gradually lessening need for economic support. The report makes several relevant findings:

- Minnesota's economic success depends on immigrants. The state's population would have started declining as of 2001, with residents leaving the state, but for the influx of immigrants.



- Immigrants link Minnesota to the world economy and make valuable contributions as employees, employers/entrepreneurs, consumers, and taxpayers.
- Building systems that support entrepreneurship is important to the state's short- and long-term success; this is an area where Minnesota lags behind the rest of the nation.
- Over time, immigrants are upwardly mobile regarding improved (lower) poverty and unemployment rates and increased home ownership rates.⁵⁰

Minnesota's overall poverty rate (household income below federal poverty levels (FPL)) is 9.3%. American Indians (24.4%) and Black people (20.9%) in Minnesota have the highest poverty rates among all racial and ethnic groups, while non-Hispanic whites (7.4%) have the lowest. The poverty rate among all Hispanics is 14.5% and is 11.6% among all Asians. Mixed race people (two or more races) have a poverty rate of 13.6%.⁵¹

Minnesota's state demographer, Susan Brower, commenting in late 2015 about labor force trends, cited a growing gap between employers' needs and population growth and a steady

slowdown in growth of the state's workforce. She noted that falling birth rates and retiring baby boomers has resulted in insufficient workers to fill employment needs and fuel economic growth, and that immigration would need to increase considerably to maintain growth in the state's labor force. The Demographic Center estimated that the number of jobs (100,00) would far outpace the estimate growth of the labor force (21,000 workers) between 2015 and 2020 and would continue to widen thereafter. The estimates included unauthorized immigrants, who have "a very high rate of participation in the work force."⁵²

Undocumented Immigrants' Access to Minnesota Programs, Services, and Benefits

Undocumented immigrant residents of Minnesota are ineligible for many public benefit programs, including the following: General Assistance (GA); Minnesota Family Investment Program (MFIP); Diversionary Work Program (DWP); Minnesota Supplemental Aid (MSA); Supplemental Security Income (SSI); Supplemental Nutrition Assistance Program (SNAP); Emergency General Assistance; and Medical Assistance (MA) (except coverage for pregnancy and up to 365 days postpartum); MinnesotaCare; and MNsure. Prohibiting or restricting undocumented immigrants' access to programs, services, and benefits such as these creates significant barriers for immigrants and their families to maintain a minimal level of health, much less thrive and become full citizens.

Discussed below are three categories of government programs, services, and benefits in Minnesota that prohibit or significantly restrict undocumented immigrants' eligibility and access: *health care and social services*; *driver's licenses*; and *unemployment insurance and workers' compensation benefits*.

- Health care and social services. Access to health care and social services in Minnesota depends on various factors including income and immigration status and the date of immigration status. Generally, undocumented people in Minnesota are ineligible for most health care and cash assistance programs, with notable exceptions for emergency services coverage through Emergency Medical Assistance (EMA) and Medical Assistance (MA) coverage of pregnancy care and up to one year of postpartum care.⁵³
 - Legislation enacted in 2021, HF 521, amending Minn. Stat. § 256B.06, subd. 6,⁵⁴ extended MA coverage to women – including undocumented immigrant residents – during pregnancy, birth, and up to 365 days postpartum. The legislation required the Human Services commissioner to seek all federal waivers and approvals necessary to extend this coverage. Federal approval was granted, and these changes took effect July 2, 2022.⁵⁵

- Children who are in the U.S. legally (e.g., children with Temporary Protected Status (TPS), who have applied for but do not yet have asylum) are eligible for MA, the funding for which comes from the Children’s Health Insurance Program (CHIP).
- Undocumented people can receive Emergency Medical Assistance services (EMA) for medical conditions so serious that one’s health or body would be at risk without medical treatment. For example, a heart or breathing problem would qualify if, without treatment, a medical crisis would likely result. Some chronic conditions such as cancer or kidney disease may be covered; however, home health care and mental health care are considered non-emergency conditions and typically are not covered.
- Driver’s Licenses. Undocumented immigrants in Minnesota recently regained eligibility for state drivers’ licenses after being denied access to them for two decades.
 - On March 7, 2023, the Driver’s License for All bill ([HF 4](#)) became law,⁵⁶ removing a 2003 requirement that proof of legal residence be shown to obtain a state driver’s license.⁵⁷ Beginning October 2023, undocumented Minnesotans will have the opportunity to get a driver’s license and obtain insurance so they can legally drive themselves to work, school, and other places. This change was the culmination of efforts led by immigrant communities and organized initiatives like *Freedom to Drive* that spanned more than a decade.⁵⁸ The bill also was supported by the Minnesota Chamber of Commerce for workforce and public safety reasons.⁵⁹
- Unemployment Benefits and Workers’ Compensation. Generally, undocumented immigrants are ineligible for unemployment insurance and other employment assistance programs including Workforce Investment Act (WIA); Dislocated Worker Program; Senior Community Service Employment Program (SCSEP); Food Support Employment and Training Program (FSET); and Trade Adjustment Act Program (TAA).
 - Workers’ compensation benefits, however, are available to “aliens” under state law. While “alien” is not defined in the applicable law (Minn. Stat. Ch. 176), this term is generally used to refer to “noncitizens.” Minnesota courts have long held that “undocumented” immigrants (i.e., “noncitizens” or “aliens”) are not expressly excluded from these benefits under state law.⁶⁰

Legislative Activity and Outreach

A straightforward legislative proposal to address undocumented immigrants’ access to comprehensive health care coverage was introduced in the Minnesota Legislature in the 2022 session via [HF 3665](#),⁶¹ and its Senate companion bill, [SB 3618](#).⁶² These bills proposed

amending Minn. Stat. 256L.04, subd. 10 by simply deleting the text that makes undocumented immigrants ineligible for MinnesotaCare benefits.⁶³ While neither of these bills progressed beyond introduction in 2022, these, or similar, efforts will likely resume.

The Minnesota House and Senate do not have standing committees dedicated to addressing immigration-related issues. Immigration issues are relevant, however, to the equity-rooted work of the People of Color and Indigenous (POCI) caucuses and numerous other committees including, but not limited to, those that address health, health finance, social services, and unemployment compensation.

In recent years, several states have expanded access to comprehensive, affordable health care for undocumented immigrants beyond prenatal or emergency care, or care for very young babies. Although Minnesota has often been considered a leader in addressing racial and health inequities, it is now lagging behind in this important health equity area.

4. State Legislative Approaches

As of March 16, 2023, 14 states plus the District of Columbia have enacted laws extending access to health care coverage to all or age-specific subsets of undocumented immigrants. Implementation dates are staggered in various states and some states that have enacted legislation have not yet implemented their policies. This [Table of State Laws companion resource](#) provides an overview of state laws enacted to date, including jurisdiction-specific links to policy language information about age group eligibility and scope of coverage, and accountability components. Here are a few highlights from enacted state laws:

- California is believed to be the first state to enact legislation to provide coverage to all undocumented immigrant residents in the state based on income guidelines (and in addition to prenatal and up to 12 months of postpartum care); this was accomplished incrementally, with legislation extending coverage to one age group, then another, enacted over the course of about seven years (2015-2022).
- Oregon has also made undocumented immigrants of all ages eligible for comprehensive coverage (in addition to providing prenatal and up to 12 months of postpartum care). However, it is not taking enrollments from people ages 26-54 years old for budgetary reasons, at least through July 2023.
- Washington D.C. provides comprehensive coverage to children and adults of all ages (including prenatal care), regardless of immigration status.



- New York has extended health care access to undocumented immigrants ages 18 and under and 65 and up, and provides coverage for pregnant and 12 months of postpartum care to people ages 19-64 years old, regardless of immigration status, based on income guidelines.
- Eight states (Colorado, Connecticut, Maine, Massachusetts, New Jersey, Rhode Island, Vermont, and Washington) provide coverage to children/young adults in addition to providing prenatal care and up to 12 months of postpartum care. New Jersey and Massachusetts provide more limited coverage for postpartum care and additional support for emergency care.
- In December 2022, the Centers for Medicare & Medicaid Services approved Washington's application for a State Innovation Waiver under the Affordable Care Act, allowing the state to offer health and dental coverage through its health care exchange to all residents, and provide premium subsidies through a state-funded program to all people earning up to 250% of the FPL, regardless of immigration status or age. The waiver will be implemented on January 1, 2024 through December 31, 2028.

- Utah provides coverage for children ages 18 and under, based on income guidelines and other conditions.

5. Key Policy Elements

Legislation extending health care coverage to undocumented immigrants typically contains several main policy elements. Many, but not all, state laws begin with **findings** clauses that explain the goals of the legislation, and summarize relevant facts that provide justification for the legislation. Findings clauses often address the social determinants of health and describe general research findings and community-specific statistics. A **statement of purpose or intent** is often included and is recommended, preferably expressly incorporating and prioritizing health equity aims and outcomes. A **definitions** section is typically included to define key terms, assigning a particular meaning to terms used in the policy that may go beyond their dictionary definitions; for example, terms like “resident” or “treatment” may have special definitions within the law’s context. Effective legislation also includes **actionable provisions**. Actionable provisions are the muscle of the policy change; they state what changes are required to fulfill the policy’s purpose and should include specific implementation steps and requirements about who must do what and by when. Actionable provisions in legislation of this type typically specify such things as the age range(s) of covered individuals; stakeholder and community engagement or outreach processes; implementation, evaluation, and reporting requirements; and the date the legislation will take effect. They may include additional specific requirements, such as requiring tracking and reporting on health equity impacts and outcomes.

Some states have utilized **federal waivers** to offset the cost associated with offering undocumented immigrants health coverage with state funds. In 2021, Washington state lawmakers created the Universal Health Care Commission as part of an effort to help pave the way towards universal health care coverage in the state.⁶⁴ Another part of this effort was the state’s application for a State Innovation Waiver (also known as a “1332 waiver”) under the Affordable Care Act in May 2022, asking for the flexibility to extend health and dental coverage through its health care exchange to all residents, and to provide premium subsidies through a state-funded program to all people earning up to 250% of the FPL, regardless of immigration status or age.⁶⁵ The Centers for Medicare & Medicaid Services approved Washington’s application in December, and the waiver will be implemented January 1, 2024, through December 31, 2028.⁶⁶

Colorado also requested and was granted an amendment to its 1332 waiver in June 2022, to allow it to implement a new public health care plan that the state is encouraging insurers to

offer at lower costs to consumers in the individual and small-group market. The amended waiver will allow the state to keep the savings from reducing the cost of health insurance; if the state reduces the cost (saving the federal government money), it can keep these “pass-through” dollars.⁶⁷ The state expects to receive about \$1.5 billion in federal dollars over the course of the five year waiver and plans to use the savings to subsidize care for undocumented immigrants and others by covering premiums.⁶⁸ For more information about Colorado’s efforts, see the companion resource case study available at <https://www.publichealthlawcenter.org/health-equity-and-policy>.

6. Innovative Policy Elements

Among jurisdictions that have enacted legislation, some have included innovative policy elements designed to improve the legislation’s effectiveness and further health equity aims. A few examples of innovative elements are noted below:

- Health care expansion legislation should center health equity. Some legislation accomplishes this by explicitly including equity elements in reporting requirements. As an example, Oregon’s legislation, which expanded the state’s coverage of undocumented individuals to include people 25 years old and under and those 55+ years old, requires the Oregon Health Authority to convene a work group and develop an implementation plan that will ensure community feedback representing a “health equity perspective” is received. See [HB 3352](#).⁶⁹
- Some legislation requires reporting back to the legislature before the legislation takes effect. Colorado, for instance, requires a report to the legislature detailing the responsible state agency’s progress and implementation plan for extending coverage for its State Medical Assistance and State Children’s Basic Health Plan during the year before the changes to law will be implemented. See [C.R.S. 25.5-2.104](#).⁷⁰
- Most legislation extending health coverage to undocumented immigrants requires participants to have incomes at or below some percentage relative to the FPL – for example, 200% of the FPL. In 2007, the State of Washington enacted legislation that allowed undocumented children under the age of 19 to receive coverage. The legislation incorporates a novel premium schedule allowing families that exceed the income eligibility requirements to participate for a specified premium fee. Premium fees are based on family income and are designed to avoid posing a barrier to enrollment. See [R.C.W. 71.09.470](#).⁷¹

- Legislation may include provisions that seek to protect participants' confidentiality. Including this type of provision is likely to build trust within the undocumented community and may increase program use. Vermont took this approach in its 2021 legislation, extending health care and prescription drug coverage to undocumented individuals under 19 years old and pregnant individuals. The legislation includes policy language that explicitly prohibits transferring program applicant or enrollee information to the federal government. See [Act. No. 48](#).⁷²
- Including specific language addressing whether migrant seasonal workers are eligible for coverage can increase understanding of the range of who is covered by the legislation and may increase program participation. The [Vermont legislation](#) mentioned above is an example; it includes language clarifying that eligible workers include "migrant workers who are employed in seasonal occupations."⁷³
- Legislation in several states include express requirements for community outreach to undocumented immigrants. These requirements are designed to maximize enrollment and retention in applicable health care programs and ensure that underserved populations have access to applicable resources. [Oregon legislation](#) specifically tasks the state's health agency with providing education and engaging communities, specifically members of racial, ethnic, and language minority groups and those located in geographically isolated areas of the state.⁷⁴
- States extending partial coverage have identified creative ways to simultaneously limit enrollment for health care coverage programs while simultaneously maximizing the benefits for enrollees. For example, Connecticut, which provides state-funded MA to people under 19 years of age, regardless of immigration status, limits enrollment to children under the age of 12 but allows enrolled children to retain benefits until they reach the age of 19. See sections 232 and 233 of Connecticut's [Public Act No. 22-118](#).⁷⁵
- At least one state law expands MA programs to cover at least a portion of the undocumented population without explicitly mentioning "undocumented immigrants" or "immigration status." For example, Massachusetts's legislation, enacted in 2003, expanded access to primary and preventative health care coverage for uninsured people under the age of 19 who are otherwise "ineligible for medical benefits." See [Mass. Gen. Laws ch. 118E § 10F](#).⁷⁶ Providing guaranteed continuity of enrollment is one strategy to increase health coverage program use. In 2022, California passed legislation requiring that all children under five years of age be continuously eligible for the state's Medi-Cal program, regardless of income eligibility. See [SB 184](#).⁷⁷ Similarly, Colorado and Maine automatically



enroll infants born to someone eligible for coverage during pregnancy for one year. See Colo. Rev. Stat. § 25.5-8-109 (2022) and Me. Stat. 22 § 3174-FFF (2022).

- One strategy to increase health coverage enrollment is to support technical assistance providers who assist applicants with the application process. Illinois’s legislation provides that the Department of Health Care and Family Services may have discretion to approve “technical assistance payments” to providers who have assisted with an approved application. See HB 806.⁷⁸
- Legislation extending access to health care coverage presents a great opportunity to build key public health prevention work into the health care system. The Massachusetts law mentioned above explicitly states that the coverage the state provides to undocumented children extends to the provision of smoking prevention education information and materials to the child’s parent or guardian.⁷⁹
- Some states have taken a staggered approach to expanding access to health coverage to the undocumented community. Often, states have begun by extending access to

coverage to children under 19 years of age and/or people who are pregnant/postpartum, then extending access to coverage to seniors ages 55+, and then progressing to extend access to intermediate adult age groups. The states of California, Illinois, and Oregon have all made use of some variation of this strategy. Case studies for each of these states are available as companion resources at <https://www.publichealthlawcenter.org/health-equity-and-policy>.

7. Related Policy Measures

Health care access is not the only barrier facing undocumented immigrants. They are ineligible for most means-tested benefits due to numerous immigration status eligibility requirements. One notable exception is the *Special Supplemental Nutrition Program for Women, Infants, and Children* (WIC).⁸⁰ Undocumented mothers, expecting mothers, and children under five may receive nutrition assistance, breastfeeding support, and other services, regardless of immigration status, via WIC.⁸¹

Several states and the District of Columbia have enacted other types of legislation that enable undocumented immigrants to obtain certain health, social service, and/or economic benefits and services they would otherwise be blocked from due to their immigration status.

One legislative strategy, used successfully in Colorado, has been to create parallel, equivalent systems and programs in instances where current programs prohibit participation. For example, recent Colorado legislation removed the requirement that an individual's lawful presence must be verified to be eligible for state and local public benefits (SB21-199).⁸² Colorado has passed a number of other, more narrowly focused measures that benefit undocumented immigrants including SB21-009 (creating a reproductive health care program that offers contraception and counseling),⁸³ SB21-233 (requiring a study to investigate a wage replacement program for unemployed undocumented immigrants), HB21-1194 (establishing an immigration legal defense fund),⁸⁴ HB21-1054 (removing lawful presence verification from the requirements to receiving public or assisted housing), SB21-077 (removing lawful presence verification from certain licensing and credentialing requirements),⁸⁵ and HB22-1155 (reducing the criteria needed to qualify for in-state tuition).⁸⁶

In addition, in some of the other states that have expanded health coverage to some or all undocumented immigrant residents, additional legislative mechanisms have been used to expand public benefits to all noncitizens. For example, California recently expanded the *California Food Assistance Program* to include all eligible individuals aged 55 and above, regardless of immigration status (SB 187 Sec. 84).⁸⁷ Similarly, Illinois has expanded eligibility

for an energy assistance program to reach *all* low-income state residents (SB 0265)⁸⁸ and has prohibited requiring proof of immigration status as an eligibility criterion for a rental assistance program implemented during the COVID-19 pandemic (HB 2877).⁸⁹ Moreover, in 2021, Illinois enacted legislation requiring its Department of Human Services to create a “know your rights” public information campaign that is inclusive of all immigrants, regardless of immigration status (HB 0709).⁹⁰

Expanding health coverage is just one piece of the puzzle. Achieving equity, regardless of immigration status, requires ensuring that other essential services are equally accessible. Many of the policy strategies discussed in this summary may be helpful to consider, not only as they pertain to legislative policies to extend access to and use of affordable, comprehensive healthcare coverage, but also as they relate to expanding access to other critically important, means-tested public benefits.

8. Limitations

The limitations below speak to some of the shortcomings of current state policy efforts to extend or expand access to health care coverage to undocumented immigrants in the U.S. Even where access to health care coverage is expanded, health literacy and health care quality (e.g., quality and effectiveness of communications and comfortability with health care providers) can remain as barriers for undocumented immigrants.⁹¹

- To the extent that undocumented immigrants nationwide cannot obtain access to health care coverage, immigration policy concerns (e.g., public charge fears and historical and generational distrust of governmental institutions) will likely continue to function as pervasive barriers to seeking public benefits.⁹²
- Fear of deportation may lead undocumented immigrants to avoid seeking care, thereby risking severe health complications,⁹³ which could negatively affect public health.
- Because of their undocumented status, people may be ineligible for sick leave days and may have difficulty negotiating time off from work to seek care.⁹⁴
- Among the reasons for lack of access to healthcare coverage and services, limited English language proficiency, lack of awareness of available services, and administrative difficulties in obtaining healthcare and finances have been cited as most common.⁹⁵
- Studies have shown that people with limited English language proficiency are at higher risk of poor health outcomes and have decreased access to health care because they have

increased difficulty in understanding their health status and accessing preventative services.⁹⁶

9. Recommendations

The following recommendations have emerged based on a review of the currently known laws for expanding access to comprehensive health care for all, and especially undocumented immigrants:

- a. Prioritize and ensure robust community participation and engagement in planning, e.g., via coalition or coalition-like activity.
 - Identify and conduct outreach to representative working groups or coalitions.
 - Build relationships with community leaders, seeking community buy-in and partnerships.
 - Confer with relevant legislative caucuses and with academic researchers addressing racial and health inequities and disparities, and immigrants' rights.
 - Recognize that it will take time and sustained community-led efforts to establish trust and alleviate immigrants' fears regarding access to health care and use of health care services.
 - Conduct educational outreach to specific immigrant communities about current laws and immigrants' rights to health care.
 - Engage collaboratively with immigration legal service providers trusted by undocumented immigrant residents. Immigration attorneys may be available for presentations and to respond to common questions related to potential legal implications such as the public charge rule. By partnering with and distributing information to the public about reputable immigration law legal advocacy organizations, health care providers can take meaningful steps to help prevent patients from being deported or falling victim to immigration law fraud.
 - For example, a list of Minnesota Immigration Legal Organizations in Minnesota, compiled from the Immigration Advocates Network, is available at: <https://www.immigrationadvocates.org/legaldirectory/search?state=MN>. Similar lists likely exist for other states.



- b. Conduct a racial and health equity impact policy assessment as part of developing and vetting sample policy language, using a racial and health equity impact policy assessment tool.
- c. When developing legislative policy language, include specific processes to advance racial and health equity goals by requiring inclusion of certain components such as: community engagement in decision-making, including policy-making and policy implementation, evaluation, and reporting processes and mandates; educational outreach about enrollment and access to services; development and dissemination of multi-language materials to effectively reach undocumented immigrant communities and individuals; and ready availability of linguistically and culturally sensitive materials.⁹⁷
- d. Additional components to consider include:
 - Prohibit the sharing of certain personal information with the federal government. Limiting unnecessary data-sharing with federal government bodies helps protect

immigrants' right to unfettered access to comprehensive health care, without placing them in jeopardy of deportation or other harmful sanctions.

- Enable undocumented immigrants to buy in or pay premiums if their incomes increase above the established FPL threshold.
 - Define “children” to include all youth under the age of 21 years old.
 - Reduce paperwork requirements to ease, support, and boost enrollment.
 - Require public information materials to be developed in multiple languages, tailored to the state’s immigrant populations.
- e. If it is not possible to extend coverage to all people at once, use an incremental approach as California and other states have done, starting with children, seniors, and pregnant and postpartum people.
- f. Encourage and support training of health care and legal service providers on state and federal legal mandates.
- g. Encourage or require training of health care providers to facilitate their understanding of the needs of immigrant patients.
- h. Enhance support for safety-net providers (public, nonprofit, and free clinics that render care to the population) through state-funded mechanisms.

Conclusion

Everyone deserves to be healthy. Access to comprehensive, affordable health insurance coverage for all people, regardless of immigration status, is critical to advancing health equity, sustaining the U.S. and state economies and workforce, and reducing health disparities. More and more states are finding ways to use the power of state law and policy to expand and fund this access, and make it possible for all of us to live in communities where everyone has access to the health care services and other systems we all need to live healthy lives.

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Appendix A: Beyond Health Care Expansion: State Approaches to Expanding Access to Other Resources for Undocumented People

Expanding access to affordable, comprehensive health care coverage for undocumented immigrants is crucial for achieving racial health equity, and it is part of a larger set of strategies. Because of structural racism and xenophobia, undocumented people experience inequitable access to a wide variety of resources related to the social determinants of health, in addition to health care, in ways that drive poorer health outcomes for them and their families. These range from educational support services to nutrition assistance programs to legal representation. Many states have sought to expand noncitizen eligibility for such benefits and services. The following list offers several examples of state-level legislation. This list is not exhaustive but presents a starting point for understanding what types of benefit and service expansion efforts have been established through state law.

- Assistance for domestic violence victims.
 - Oregon’s [Temporary Assistance for Domestic Violence Survivors \(TA-DVS\)](#) program may be accessible to undocumented immigrants who are pregnant or have children, meet the income eligibility requirements, and are fleeing domestic violence.¹
- Pandemic-related frontline worker relief.
 - Oregon’s [HB 5202 \(Sec. 324\)](#) established the [Oregon Worker Relief Fund](#) to support Oregonians out of work due to the COVID-19 pandemic who were not otherwise eligible for unemployment insurance.²
 - In 2020, [California allocated pandemic relief funds](#) for workers, including undocumented workers, who did not qualify for other types of assistance.³
- Expanding eligibility for energy and rent assistance programs.
 - In 2021, Illinois passed [SB 0265](#) expanding eligibility for its Energy Assistance Program to all eligible low-income residents, regardless of immigration status.⁴
 - In Colorado, [HB21-1054](#) removed verification of lawful presence requirements from public or assisted housing, housing services, housing assistance, and other benefit eligibility criteria.⁵
- Expanding state-based nutrition assistance programs.

- In 2022, California passed [SB 187](#), which provides for an expansion of the California Food Assistance Program (CFAP) to include all residents aged 55 years and up, regardless of immigration status.⁶
- Assistance with paying for prescription drugs.
 - Undocumented immigrants are eligible to participate in Oregon’s [Prescription Drug Program](#).⁷
 - Senior citizens and persons with disabilities who are otherwise ineligible for means-tested benefits due to immigration status may be eligible for limited assistance in paying for prescription drugs under [Illinois law](#).⁸
- Investing in mobile health care units.
 - In 2022, Oregon passed [HB 4052](#) establishing an advisory committee to provide guidance on establishing and operating a pilot program that will fund two culturally and linguistically specific mobile health units within the state.⁹
- Providing accessible reproductive health care.
 - In [HB 0370](#), Illinois declared its commitment to provide reproductive healthcare to all people, regardless of immigration status.¹⁰
 - In 2021, Colorado passed [SB 21-009](#), creating a reproductive health care program, which includes a provision of contraceptives and counseling services, that undocumented immigrants are eligible to participate in.¹¹
- Requiring state-funded “know your rights” campaigns.
 - In 2021, Illinois passed [HB 0709](#), which tasks the Department of Human Services with creating and executing a public information campaign to inform all immigrants, asylum seekers, and refugees of their rights, including undocumented immigrants.¹²
- Increasing access to legal representation.
 - California legislation [AB 2193](#) expands the pre-existing state requirement that legal counsel be appointed to represent low-income individuals in civil matters concerning basic human rights to all people, regardless of citizenship or immigration status.¹³
 - California [AB 0829](#) requires counties to make best efforts to provide undocumented dependents in the foster care system with access to immigration legal services.¹⁴

- Colorado legislation, [HB21-1194](#) creates the Immigration Legal Defense Fund.¹⁵
- Removing citizenship or immigration status criteria from certain licensure requirements.
 - Illinois prohibits denying a teaching license solely on the basis of citizenship or immigration status. See [SB 3988](#).¹⁶
 - Colorado [SB21-077](#) removed verification of lawful presence requirements from certain licensure and individual credentialing processes.¹⁷
- Providing in-state tuition eligibility and other resources related to higher education.
 - In 2021, Illinois passed [HB 3438](#) requiring Illinois higher education institutions to designate an employee as the “Undocumented Student Liaison” and encouraging campuses to develop an “Undocumented Student Resource Center.”¹⁸
 - In 2001, [AB 540](#) required that all California residents who have lived in the state for three or more years be eligible to receive in-state tuition and financial aid benefits.¹⁹
 - Colorado recently reduced its residency requirement to be eligible for in-state tuition from three years to twelve months. See [HB22-1155](#).²⁰

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Endnotes

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