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Noncitizens' Access to Health Care

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SUMMARY

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Noncitizens' 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.

Recent estimates from the U.S. Census Bureau found that an estimated 47.8 million foreign-born people live in the United States, representing 14.3% of the total U.S. population. Just under half (48%) of the foreign-born population are non-U.S. citizens. Estimating the size of the noncitizen populations who may be eligible for federal health care programs is challenging because population surveys do not capture noncitizens' specific immigration statuses. 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

Estimating the size of various noncitizen[4] populations potentially eligible for various health programs is constrained by what data are collected by federal agencies and research organizations. Using data on the foreign-born population would overestimate the noncitizen population because the foreign-born population includes naturalized citizens. (An estimated 47.8 million foreign-born people lived in the United States in 2023, representing 14.3% of the total U.S. population.[5]) Data are available on the total noncitizen population (estimated at 22.9 million

[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 in the "Immigrants' Health Care Use" section of this CRS report.

[2] U.S. Bureau of Labor Statistics. "Coverage in employer medical care plans among workers in different wage groups in 2022," March 9, 2023, https://www.bls.gov/opub/ted/2023/coverage-in-employer-medical-care-plans-among-workers-in-different-wage-groups-in-2022.htm#:~:text=Twenty%2Dsix%20percent%20of%20private,had%20access%20to%20such%20plans.; and Jennifer Tolbert, Patrick Drake, and Anthony Damico, "Key Facts about the Uninsured Population," Kaiser Family Foundation, December 18, 2023, 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] As used in this report, the term "noncitizens" refers to individuals who are not citizens of the United States (i.e., neither U.S.-born nor naturalized). For the purposes of this report, the term "U.S. citizen" includes noncitizen U.S. nationals (e.g., persons born in American Samoa). 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*, 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*.

[5] for more information, see CRS In Focus IF11806, *Citizenship and Immigration Statuses of the U.S. Foreign-Born Population*.

in 2023),[6] but only a subset of that population will be eligible for the programs discussed in this report.

A variety of survey and administrative data sources have been used in recent years to estimate the size of subsets of the foreign-born population. These estimates, spanning different data sources, suggest that among the foreign-born population[7]

- 25.0 million are naturalized citizens;[8]
- 12.7 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]

The data available on the noncitizen population generally do not include the granularity needed to estimate the size of this population that is eligible for a given health program. For example, as outlined in this report, subsets of the LPRs are not eligible for certain healthcare programs, while subsets of the unauthorized population are eligible for certain programs (e.g., Deferred Action for Childhood Arrivals [DACA] recipients).[12] Certain nonimmigrants are eligible for certain healthcare programs discussed in this report, while others are not. Thus, CRS cannot look at these data and determine the number of noncitizens eligible for any particular program.

Immigration Categories

Noncitizen eligibility for certain federal health care programs depends on the program's criteria and the immigration status of the individual. The universe of immigration categories is vast and are not mutually exclusive; an individual can potentially belong to more than one of these categories at the same time.[13] This report focuses on the categories relevant to the laws and regulations relating to federal health care programs, including the following (in alphabetical order):

[6] U.S. Census Bureau, "B05002, Place of Birth by Nativity and Citizenship Status," https://data.census.gov/table?q=B05002&g=010XX00US.

[7] Because the data included in this list come from various sources and cover different years, they do not add up to the U.S. Census Bureau's estimate of 47.8 million foreign-born people living in the United States in 2023.

[8] U.S. Census Bureau, Nativity and Citizenship Status in the United States, 2023, Table B05001, http://data.census.gov.

[9] This number is based on the most recent estimates from the Department of Homeland Security (DHS); see Sarah Miller and Bryan Baker, "Estimates of the Lawful Permanent Resident Population in the United States and the Subpopulation Eligible to Naturalize: 2023," DHS, Office of Immigration Statistics, October 2023, https://ohss.dhs.gov/sites/default/files/2023-12/2023_1017_plcy_lawful_permenent_resident_population_estimate_2023.pdf.

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

[11] This number is based on the most recent DHS estimates; see Bryan Baker and Robert Warren, "Estimates of the Unauthorized Immigrant Population Residing in the United States: January 2018–January 2022," April 2024, https://ohss.dhs.gov/sites/default/files/2024-06/2024_0418_ohss_estimates-of-the-unauthorized-immigrant-population-residing-in-the-united-states-january-2018%25E2%2580%2593january-2022.pdf.

[12] DHS estimates of the unauthorized population include recipients of DACA, Temporary Protected Status (TPS), and other forms of prosecutorial discretion. See ibid., p. 1.

[13] For example, asylum applicants can potentially belong to another immigration category. TPS holders may also still have the immigration status they had before applying for TPS (e.g., a foreign student or tourist visa) and/or may have obtained another status (e.g., parolee or asylee).

- **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 residing abroad, who apply for an immigrant visa from the Department of State).[14]
- **Asylees** are foreign nationals who fled 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] Asylees meet the definition of a refugee (see below) in terms of persecution or a well-founded fear of persecution but are present in the United States or at a land border or port of entry to the United States. This term refers to those granted asylum; it does not include asylum applicants.
- **Asylum applicants** are those that have submitted an application for asylum and are awaiting a final decision on their application.
- **Certain noncitizens who entered the United States before January 1, 1982**,[16] which refers to noncitizens who were granted temporary legal status and were then able to adjust to LPR status pursuant to the Immigration Reform and Control Act of 1986 (IRCA; P.L. 93-603).
- **Compacts of Free Association (COFA) migrants** are citizens of the Marshall Islands, Micronesia, or Palau permitted to live in the United States indefinitely under the terms of those nations' COFA with the United States.[17]
- 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 nationals of Cuba or Haiti who have been paroled into the United States at any time, are in removal proceedings,[19] or have a pending asylum application and do not have a final, nonappealable order of removal.[20]

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

[15] For more information, see CRS Report R45539, *Immigration: U.S. Asylum Policy*.

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

[17] The Consolidated Appropriations Act, 2021 (P.L. 116-260) modified PRWORA by adding individuals who are lawfully residing in the United States under COFA to the list of qualified aliens, but only with respect to Medicaid. This provision was later expanded by P.L. 118-42 (Division G, Title II, §209(f)) to add COFA migrants to the list of qualified aliens under PRWORA for public benefit programs generally (i.e., not only for Medicaid). P.L. 118-42 also exempted these individual from certain other restrictions under PRWORA, including the five-year bar (discussed in the "Five-Year Bar: Additional Restriction for Qualified Aliens" section below). For more information, see CRS In Focus IF11912, *Noncitizen Eligibility for Medicaid and CHIP*. 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.*

[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] Deportation is referred to as "removal" in immigration law.

[20] 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 DHS, USCIS, Cuban Haitian Entrant Program, https://www.uscis.gov/archive/archive-news/cuban-haitian-entrant-program-chep.

- Noncitizens with **deferred action** are those who are *inadmissible*[21] or deportable but DHS granted them a discretionary reprieve from removal.[22]
- **Deferred Action for Childhood Arrivals (DACA)** recipients are unauthorized childhood arrivals who DHS granted renewable two-year protection from removal.[23]
- **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.[24]
- **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).
- **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.[25]
- **LPRs** are foreign nationals permitted to live in the United States permanently.[26]
- 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 used for each program. (If applicable, the definition utilized by the programs discussed in this report is explained in the relevant section.)
- **Noncitizens admitted to the United States**, which can refer to any noncitizen who was lawfully admitted (e.g., as a nonimmigrant or refugee).[27]
- **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.

[21] 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 In Focus IF12662, *Immigration: Grounds of Inadmissibility*.

[22] *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*.

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

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

[25] 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 (Afghans: 8 U.S.C. §1101 note; Iraqis: 8 U.S.C. §1157 note). For more information, see CRS Report R43725, *Iraqi and Afghan Special Immigrant Visa Programs*.

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

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

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

Immigration parole is granted on a case-by-case basis.[29] Since 2021, the Biden Administration has used discretionary parole authority to enable persons with particular nationalities to lawfully enter and reside in the United States.[30] These initiatives are distinct from the standard process through which persons outside the United States can apply to DHS's USCIS for immigration parole.[31]

- **Afghan parolees** refers to Afghans[32] paroled into the United States between July 31, 2021, and September 30, 2023.[33]
- **Cuban, Nicaraguan, Haitian, and Venezuelan (CNHV) parolees** refers to individuals from those countries who were paroled into the United States since January 2023.[34]
- **Ukrainian parolees** refers to Ukrainians[35] paroled into the United States between February 24, 2022, and September 30, 2024.[36]

- **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.[37]

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

[30] For more information about these initiatives, see CRS Report R47654, *Immigration Options for Immigration Parolees*.

[31] For information on the standard process, see DHS, USCIS, "Humanitarian or Significant Public Benefit Parole for Individuals Outside the United States," https://www.uscis.gov/humanitarian/humanitarianpublicbenefitparoleindividualsoutsideUS.

[32] It also refers to individuals with no nationality who last habitually resided in Afghanistan.

[33] 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. Afghans are eligible for these benefits if they were paroled into the United States between July 31, 2021, and September 30, 2023. (The end date was originally September 30, 2022, but it was amended by P.L. 117-328) Additionally, those paroled after September 30, 2022, with a qualifying family connection (e.g., child, spouse, or parent of specified individuals) are eligible for benefits to the same extent as refugees. See INA §101 note; 8 U.S.C. §1101 note.

[34] In January 2023, DHS implemented new parole processes for Cubans, Haitians, and Nicaraguans, along with an updated process for Venezuelans. The CHNV processes require a U.S.-based supporter to initiate the application process on behalf of a beneficiary and agree to provide financial support. Potential beneficiaries are subject to a number of ineligibilities. The CHNV processes are subject to a combined monthly cap of 30,000 beneficiary advance travel authorizations. DHS had established a Venezuelan parole process in October 2022. It updated this process in conjunction with establishing new processes for nationals of Cuba, Haiti, and Nicaragua in January 2023. For more information, see CRS Report R47654, *Immigration Options for Immigration Parolees*.

[35] It also refers to non-Ukrainian individuals who last habitually resided in Ukraine.

[36] In response to Russia's renewed invasion of Ukraine in February 2022, Congress passed the 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 State Department's Reception and Placement Program for newly arriving refugees) until the end of their parole term. Ukrainians are potentially eligible if they were paroled into the United States between February 24, 2022, and September 30, 2024 (the end date was amended by P.L. 118-50 [Division B, §301]) or those individuals' spouses or unmarried children under age 21 who are paroled into the United States after September 30, 2023. See INA §101 note; 8 U.S.C. §1101 note.

[37] 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.

- **Special Agricultural Workers** are certain individuals granted legal status through the IRCA (P.L. 93-603). The law granted eligible individuals temporary residence; they could later apply for permanent residence.[38]
- **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.[39]
- **Temporary Protected Status (TPS)** holders are foreign nationals from designated countries granted temporary relief from removal due to armed conflict, natural disaster, or other extraordinary circumstances in their home countries that prevent their safe return.[40]
- **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.[41]
- Noncitizens who have **violated the terms of their status**[42] (e.g., a nonimmigrant who worked without authorization or overstayed their visa).
- **Violence Against Women Act (VAWA) Self-Petitioners** refers to certain foreign nationals who have been subject to battery or extreme cruelty in the United States by a spouse or other household member, foreign nationals whose children have been subject to battery or extreme cruelty, and noncitizen children of foreign nationals who have been subject to battery or extreme cruelty. 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.[43]
- Certain foreign nationals present in the United States who do not qualify for asylum 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.[44]

[38] INA §210; 8 U.S.C. §1160.

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

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

[41] Subsequent to the enactment of PRWORA, lawmakers enacted the Victims of Trafficking and Violence Protection Act of 2000 (P.L. 106-386). It made victims of trafficking eligible for benefits and services "under any Federal or State program" to the same extent as refugees (22 U.S.C. §7105(b)(1)). As a result, victims of trafficking may be eligible for Medicaid and CHIP. For more information, see CRS Report R46584, *Immigration Relief for Victims of Trafficking*.

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

[43] "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.

[44] 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."[45] 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.[46]

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.[47]

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."[48] 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. [49] More recent studies are less comprehensive, but have similar findings where most immigrant populations rate their health as excellent and had lower rates of certain chronic conditions.[50] The health status of immigrants is not uniform and may vary, for example, by immigration pathway. For examples, researchers found that refugees have higher rates of chronic conditions compared to other types of immigrant populations and the U.S.-born population.[51]

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

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

[47] 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.

[48] Ibid., p. 385.

[49] 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.

[50] Drishti Pillai et al., *Health and Health Care Experiences of immigrants: The 2023 KFF/LA Times Survey of Immigrants*, Kaiser Family Foundation (KFF), September 17, 2023, https://www.kff.org/racial-equity-and-health-policy/issue-brief/health-and-health-care-experiences-of-immigrants-the-2023-kff-la-times-survey-of-immigrants/; and Arturo Vargas Bustamante, "Health Policy Challenges Posed by Shifting Demographics and Health Trends Among Immigrants to the United States," *Health Affairs*, vol. 40, no. 7 (July 2021), pp. 1028-1037.

[51] 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.

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 published in 2020 of national health care use, the authors found that unauthorized immigrants had fewer visits and lower annual per person 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.[52] In a more recent study published in 2024, researchers also found that expenditures were lower for immigrant populations (both authorized and unauthorized). They also found no significant differences in emergency room or Medicaid expenditures between immigrants and U.S.-born citizens, but found that immigrant populations use the emergency room more than the U.S.-born population.[53] Other studies have found 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.[54] 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.[55] Researchers have also found that some (approximately one-quarter) of immigrants report being treated unfairly by the health providers they do see, such as perceptions of being treated differently because of race or ethnicity and challenges accessing timely translation services.[56]

Public and Private Health Insurance Coverage

Comprehensive studies of insurance coverage generally do not include information on immigration status[57] as such, estimates of the insurance status of the immigrant population are rare. However, one recent study, estimated that as of 2023 18% of lawfully present adult immigrants were uninsured, as were 50% of unauthorized adult immigrants.[58] In comparison, 8% of U.S.-born adults were uninsured in 2023.[59]

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

[52] 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).

[53] Drishti Patel and Samantha Artiga, *Immigrants Have Lower Health Care Expenditures Than Their U.S.-Born Counterparts*, KFF, Washington, DC, July 18, 2024, https://www.kff.org/racial-equity-and-health-policy/issue-brief/immigrants-have-lower-health-care-expenditures-than-their-u-s-born-counterparts/#endnote_link_628142-1.

[54] 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.

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

[56] Drishti Pillai et al., *Health and Health Care Experiences of immigrants: The 2023 KFF/LA Times Survey of Immigrants*, KFF, September 17, 2023, https://www.kff.org/racial-equity-and-health-policy/issue-brief/health-and-health-care-experiences-of-immigrants-the-2023-kff-la-times-survey-of-immigrants/.

[57] See, for example, U.S. Census, *American Community Survey Tables for Health Insurance Coverage*, https://www.census.gov/data/tables/time-series/demo/health-insurance/acs-hi.html.

[58] KFF, "Key Facts on Health Coverage of Immigrants," September 17, 2023, https://www.kff.org/racial-equity-and-health-policy/fact-sheet/key-facts-on-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*.

[59] Ibid.

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.[60] Certain noncitizens may have limited access to employer-sponsored coverage because they are over-represented in low-skilled occupations,[61] 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.[62] 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[63] Medicaid.[64] 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).[65] Finally, they may not be eligible to purchase unsubsidized health care on ACA exchanges.[66]

Health Coverage Eligibility

This section reviews noncitizen eligibility for federally funded health insurance programs.[67] It also includes a discussion of noncitizen eligibility for financial subsidies made available through the ACA.

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

[61] 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."

[62] U.S. Bureau of Labor Statistics. "Coverage in employer medical care plans among workers in different wage groups in 2022," March 9, 2023, https://www.bls.gov/opub/ted/2023/coverage-in-employer-medical-care-plans-among-workers-in-different-wage-groups-in-2022.htm#:~:text=Twenty%2Dsix%20percent%20of%20private,had%20access%20to%20such%20plans.; Jennifer Tolbert, Patrick Drake, and Anthony Damico, "Key Facts about the Uninsured Population," Kaiser Family Foundation, December 18, 2023, https://www.kff.org/uninsured/issue-brief/key-facts-about-the-uninsured-population/.

[63] 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 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)).

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

[65] 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*.

[66] 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*.

[67] 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. For more information, see CRS Report R48163, *Foreign Nationals in the U.S. Armed Forces: Immigration Issues*. 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.

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."[68] 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.[69] 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.[70]

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 the United States."[71] PRWORA exempts certain types of programs, usually thought of as emergency programs, from its noncitizen eligibility requirements.[72] In addition, PRWORA makes an exception "for immunizations with respect to immunizable diseases and for testing and treatment of symptoms of communicable diseases."[73]

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.[74]

[68] 8 U.S.C. §1601.

[69] 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).

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

[71] 8 U.S.C. §1611(c)(1).

[72] 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.

[73] 8 U.S.C. §1611(b)(1)(C).

[74] 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 noncitizens granted withholding of removal. For more information, see CRS Report RL33809, *Noncitizen Eligibility for Federal Public Assistance: Policy Overview*.

Qualified Alien

As noted above, PRWORA states that aliens are ineligible for federal public benefits unless they are qualified aliens.[75] PRWORA created the term *qualified alien*,[76] 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,
- VAWA self-petitioners, and
- COFA migrants residing in the U.S. states and territories.

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,[77]
- Iraqi and Afghan special immigrants,[78] and
- certain Afghan and Ukrainian parolees.[79]

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.[80]

Medicaid and CHIP

Medicaid and CHIP provide health coverage 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.[81] CHIP provides health coverage to targeted low-income, uninsured children (through age 18) in families with incomes above applicable Medicaid income standards, as well as to certain pregnant women.[82]

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[75] 8 U.S.C. §1611(a).

[76] 8 U.S.C. §1641(b).

[77] 22 U.S.C. §7105(b)(1).

[78] Afghans: 8 U.S.C. §1101 note; Iraqis: 8 U.S.C. §1157 note.

[79] 8 U.S.C. §1101 note.

[80] For more information, see CRS Report R47318, *Unauthorized Immigrants' Eligibility for Federal and State Benefits: Overview and Resources*.

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

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

Eligibility for Medicaid and CHIP is determined by both federal and state law, whereby states set individual eligibility criteria within federal minimum standards. As a result, there is substantial variability in Medicaid/CHIP eligibility across states.[83] Therefore, the ways that an individual might qualify for Medicaid or CHIP are largely reflective of state policy decisions within broad federal requirements.[84]

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,
- noncitizens granted conditional entry before 1980,
- Cuban-Haitian entrants,
- VAWA self-petitioners, and
- COFA migrants residing in the U.S. states and territories.

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

- certain victims of human trafficking,[85]
- Iraqi and Afghan special immigrants,[86] and
- certain Afghan and Ukrainian parolees.[87]

With some exceptions, nonqualified aliens (see the "Qualified Alien" section above) are generally barred from Medicaid and CHIP.[88] States may choose to cover nonqualified aliens using state-only funds.

Refugees and asylees are eligible for Medicaid for the first seven years after arrival.[89] Subsequently, they may be eligible for Medicaid at a state's option.

[83] For more information, see CRS Report R43357, *Medicaid: An Overview*.

[84] In other words, states may elect to provide Medicaid coverage, or not, to otherwise-eligible qualified aliens whose eligibility is authorized under 8 U.S.C. §§1612 and 1641, and whose eligibility is not prohibited by 8 U.S.C. §§1611 or 1613. There are some groups of otherwise-eligible qualified aliens that states are required to provide Medicaid coverage to, such as refugees, asylees, noncitizens granted withholding of removal, and Cuban-Haitian entrants for seven years after entry/grant of status (8 U.S.C. §1612(b)(2)(A)); SSI recipients (8 U.S.C. §1612(b)(2)(F)); and LPRs who have worked or were credited with 40 qualifying quarters (8 U.S.C. §1612(b)(2)(B)).

[85] 22 U.S.C. §7105(b)(1).

[86] Afghans: 8 U.S.C. §1101 note; Iraqis: 8 U.S.C. §1157 note.

[87] 8 U.S.C. §1101 note.

[88] 8 U.S.C. §1611. For more information on the exceptions, see CRS In Focus IF11912, *Noncitizen Eligibility for Medicaid and CHIP*.

[89] 8 U.S.C. §1612.

Five-Year Bar: Additional Restriction for Qualified Aliens

PRWORA includes additional restrictions on noncitizen eligibility for certain federal public benefit programs, including Medicaid.[90] For example, some qualified aliens are prohibited from receiving Medicaid for the first five years after entry/grant of status (often referred to as the *five-year bar*).[91] They are the following:

- LPRs,[92]
- VAWA self-petitioners, and
- noncitizens paroled into the United States for at least one year (excluding certain Afghan and Ukrainian paroles and Cuban-Haitian entrants).

The five-year bar does not apply to individuals who have a military connection.[93] States may choose to cover LPRs within the five-year bar period using state-only funds.[94] Pregnant LPRs and children are eligible at state option for Medicaid and CHIP regardless of the date of entry.

Emergency Medicaid

Under emergency Medicaid,[95] states are required to provide limited Medicaid services for the treatment of an emergency medical condition to individuals who would otherwise qualify for full Medicaid benefits but for their immigration status. For pregnant women, emergency Medicaid includes services covered under their state plan (e.g., routine prenatal care, labor and delivery, and routine postpartum care).

Source: 42 C.F.R. §440.255(b)(2).

[90] 8 U.S.C. §§1612 and 1613. The other programs subject to additional eligibility requirements are the Supplemental Nutrition Assistance Program (SNAP; formerly the Food Stamp Program), SSI, Medicaid, and the Social Services Block Grant (SSBG). PRWORA classifies TANF, Medicaid, and SSBG as "designated federal programs" under 8 U.S.C. §1612(b)(3) and SSI and SNAP as "specified federal programs" under 8 U.S.C. §1612(a)(3). For more information, see CRS Report R46510, *PRWORA's Restrictions on Noncitizen Eligibility for Federal Public Benefits: Legal Issues*.

[91] 8 U.S.C. §1613. Some qualified aliens are exempt from the five-year bar, including refugees, asylees, noncitizens granted withholding of removal, Cuban-Haitian entrants, and COFA migrants.

[92] LPRs are exempt from the five-year bar if they previously held a status that provided the seven-year time-limited eligibility, including refugees, asylees, Cuban-Haitian entrants, and noncitizens granted withholding of removal. 8 U.S.C. §1613(b)(1).

[93] 8 U.S.C. §1613(b)(2). "Military connection" is defined as (1) an honorably discharged veteran, (2) an active-duty member of the U.S. Armed Forces, or (3) the spouse, unmarried surviving spouse, or unmarried dependent child of such veteran or servicemember. 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 eligible to enlist as well. There is also legal authority for those who do not fall into these categories to enlist in certain circumstances. For more information on noncitizens in the military, see CRS Report R48163, *Foreign Nationals in the U.S. Armed Forces: Immigration Issues*.

[94] 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 KFF, "Key Facts on Health Coverage of Immigrants," September 17, 2023, https://www.kff.org/racial-equity-and-health-policy/fact-sheet/health-coverage-of-immigrants/.

[95] 42 U.S.C. §1396b(v)(3) and 8 U.S.C. §1611(b)(1)(A).

Affordable Care Act (ACA) Health Insurance Exchanges

The ACA required all states to establish health insurance exchanges 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.[96]

Consumers may purchase coverage in their state's exchange as long as they (1) meet state residency requirements;[97] (2) are not incarcerated, except individuals in custody pending the disposition of charges; and (3) are U.S. citizens, U.S. nationals,[98] 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.[99] Because the ACA prohibits noncitizens who are not legally present (see below) from obtaining exchange coverage, these individuals are not eligible for the PTC.[100]

Noncitizen eligibility to purchase exchange plans and receive subsidies is governed by the term *lawfully present*.[101] 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,
  - VAWA self-petitioners, and
  - COFA migrants,
- nonimmigrants,
- noncitizens paroled into the United States for less than one year (with some exceptions),

[96] 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*.

[97] 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.

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

[99] 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 (which would include those who are subject to the five-year bar). 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*.

[100] 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.

[101] 42 U.S.C. §18032(a,f); 45 C.F.R. §155.20, citing 45 C.F.R. §152.2.

- certain noncitizens in temporary resident status as special agricultural workers[102] or because they are certain individuals who entered the United States before January 1, 1982,[103]
- TPS recipients and TPS applicants who have been granted employment authorization,
- certain noncitizens who have been granted work authorization (e.g., adjustment of status applicants, applicants for cancelation for removal),[104]
- family unity beneficiaries,[105]
- DED recipients,
- noncitizens with deferred action (including DACA recipients),[106]
- 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,[107]
- 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 health insurance exchanges under other federal laws:

- certain victims of human trafficking,[108]
- Iraqi and Afghan special immigrants,[109] and
- certain Afghan and Ukrainian parolees.[110]

All other noncitizens, including unauthorized immigrants, are generally not eligible to purchase plans through the health insurance exchanges, with or without subsidies. However, states can apply to the Centers for Medicare & Medicaid Services (CMS) in the Department of Health and Human Services (HHS) and the Department of the Treasury to waive certain exchange provisions, including the lawfully present provision.[111] Washington State and Maryland applied to waive this

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

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

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

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

[106] DACA recipients were previously excluded from this definition of "lawfully present." This changed with a 2024 final rule. See Department of Health and Human Services (HHS), Centers for Medicare & Medicaid Services (CMS), "Clarifying the Eligibility of Deferred Action for Childhood Arrivals (DACA) Recipients and Certain Other Noncitizens for a Qualified Health Plan through an Exchange, Advance Payments of the Premium Tax Credit, Cost-Sharing Reductions, and a Basic Health Program," 89 *Federal Register* 39392, May 8, 2024, https://www.govinfo.gov/content/pkg/FR-2024-05-08/pdf/2024-09661.pdf.

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

[108] 22 U.S.C. §7105(b)(1).

[109] Afghans: 8 U.S.C. §1101 note; Iraqis: 8 U.S.C. §1157 note.

[110] 8 U.S.C. §1101 note.

[111] Waiver applications can be found at the CMS website, "Section 1332: State Innovation Waivers," 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*.

provision in order to provide residents with access to exchange coverage regardless of immigration status.[112] Separately, Colorado applied to waive different provisions to implement a multifaceted state plan, one component of which was to use funding available through the waiver process to provide state-based financial assistance to those who are ineligible for PTCs due to immigration status.[113]

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.[114] 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 qualify for premium-free Part A (which covers hospital care and other services) because they receive (or are otherwise eligible for) Social Security or railroad retirement cash benefits.[115] Individuals may also qualify for premium-free Part A if they have end-stage renal disease (permanent kidney failure), and they (or their spouse or parent) worked for a sufficient period in jobs covered by Social Security, Medicare, or the railroad retirement system.[116] Individuals who qualify for premium-free Part A are eligible to enroll in other parts of Medicare (Parts B-D) if they meet the relevant requirements.

Generally, any noncitizen who meets Medicare's standard eligibility requirements qualifies for premium-free Part A coverage and is eligible to enroll in Part B and pay the associated premiums. However, noncitizens must be lawfully present in the United States to be eligible to *receive* premium-free Part A or Part B benefits.[117] CMS notes, "If you're not lawfully present in the U.S., Medicare won't pay for your Part A and Part B claims."[118] Additionally, noncitizens must be lawfully present in the United States to be eligible to enroll in Part C (Medicare Advantage) or Part D.[119]

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[112] 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. As of the cover date of this report, Washington's waiver application was approved for 2024 through 2028, and Maryland's waiver application was pending.

[113] See CMS, "Colorado: State Innovation Waiver – Amendment," June 23, 2022, https://www.cms.gov/files/document/1332-co-amendment-fact-sheet.pdf. As of the cover date of this report, Colorado's waiver amendment application was approved for 2023 through 2027.

[114] For more information on Medicare, see CRS In Focus IF10885, *Medicare Overview*.

[115] Premium-free Part A coverage for Social Security or railroad retirement beneficiaries under age 65 is generally limited to those who receive total and long-term disability benefits and meet certain other criteria. Federal, state, or local government employees who are subject to the Medicare payroll tax (but not the Social Security payroll tax) qualify for premium-free Part A if they worked for a sufficient period in Medicare-qualified government employment.

[116] For more information on eligibility for premium-free Part A, see CMS, "Original Medicare (Part A and B) Eligibility and Enrollment," https://www.cms.gov/medicare/enrollment-renewal/original-part-a-b; and CMS, Office of the Actuary, *Brief Summaries of Medicare & Medicaid*, November 1, 2023, pp. 8-9, https://www.cms.gov/files/document/brief-summaries-medicare-medicaid-november-1-2023.pdf.

[117] 8 U.S.C. §1611(b)(3) and HHS, CMS, "Medicare Program; Contract Year 2016 Policy and Technical Changes to the Medicare Advantage and the Medicare Prescription Drug Benefit Programs," 80 *Federal Register* 7912, 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," August 1, 2023, https://secure.ssa.gov/poms.nsf/lnx/0300204010.

[118] CMS, "How does Medicare work?," https://www.medicare.gov/basics/get-started-with-medicare/medicare-basics/how-does-medicare-work.

[119] Ibid. and 42 C.F.R. §§422.50(a)(7) and 423.30(a)(1)(iii). See also 80 *Federal Register* 7912, 7920.

Individuals aged 65 and older who do not meet the requirements for premium-free Part A may qualify for Medicare under special eligibility provisions.[120] Specifically, these individuals are eligible to enroll in Part B and enroll in Part A by paying a premium (premium Part A) 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.[121] Individuals aged 65 and older who enroll in Part B (or Parts A and B) under these special provisions are eligible to enroll in other parts of Medicare if they meet the relevant requirements. LPRs who meet the special provision requirements are eligible to receive premium Part A or Part B benefits or to enroll in Part C or Part D.[122] The special eligibility provisions do not apply to any other noncitizens.[123]

Medicare uses the same regulatory definition of "lawfully present in the United States" that applies to Social Security.[124] (Note: this definition of "lawfully present" is distinct from the one used for ACA health insurance exchanges discussed earlier.) Noncitizens determined to be lawfully present in the United States for Medicare purposes 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,
  - VAWA self-petitioners, and
  - COFA migrants;
- noncitizens who have been inspected and admitted to the United States and have not violated the terms of their status;
- noncitizens paroled into the United States for less than one year (with some exceptions);

[120] Individuals aged 65 or older may not qualify for premium-free Part A because they do not receive (or are not otherwise eligible for) Social Security or railroad retirement cash benefits, or because they (or their spouse or parent) did not work for a sufficient period in covered employment. Older adults who never receive Social Security cash benefits include late-arriving immigrants and infrequent workers. For more information, see SSA, "Never Beneficiaries, Aged 60 or Older, 2024," https://www.ssa.gov/policy/docs/population-profiles/never-beneficiaries.html.

[121] 42 U.S.C. §§1395i-2(a) and 1395o(a), 42 C.F.R. §§406.20(b)(2) and 407.10(a)(2), SSA, POMS, "HI 00801.131 Eligibility for Premium-HI," October 26, 2022, https://secure.ssa.gov/apps10/poms.nsf/lnx/0600801131; SSA, POMS, "HI 00805.005 Eligibility for SMI," October 31, 2022, https://secure.ssa.gov/apps10/poms.nsf/lnx/0600805005; and SSA, POMS, "GN 00303.800 Eligibility Under the HI/SMI Program for Uninsured Individuals," February 22, 2024, https://secure.ssa.gov/poms.nsf/lnx/0200303800. Under the special eligibility provisions, individuals aged 65 and older who do not qualify for premium-free Part A must be enrolled in Part B to be eligible to enroll in premium Part A.

[122] LPRs are qualified aliens and are by definition lawfully present in the United States for purposes of Medicare.

[123] The special eligibility provisions that permit individuals aged 65 and older who do not qualify for 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. In addition, these provisions generally do not apply to individuals under age 65, regardless of their citizenship or immigration status.

[124] 8 C.F.R. §1.3 (formerly 8 C.F.R. §103.12). See 80 *Federal Register* 7912, 7919-7920, and 7922. See also SSA, POMS, "RS 00204.010 Lawful Presence Payment Provisions."

- certain noncitizens in temporary resident status as special agricultural workers[125] or certain individuals who entered the United States before January 1, 1982;[126]
- TPS recipients;
- family unity beneficiaries;[127]
- DED recipients;
- noncitizens with deferred action (including DACA recipients[128]);
- noncitizen spouses or children of U.S. citizens with an approved visa petition who have a pending application for adjustment of status; and
- 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.[129]

The following noncitizens are not specifically mentioned in the lawful-presence regulation but effectively meet Medicare's lawful-presence requirement under other federal laws:

- certain victims of human trafficking,[130]
- Iraqi and Afghan special immigrants,[131] and
- certain Afghan and Ukrainian parolees.[132]

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	Medicare
Adjustment of status applicants	No[a]	Yes	Yes, if a spouse or child of U.S. citizen
Afghan parolees	Yes[b]	Yes	Yes
Asylees	Yes[b]	Yes	Yes
Asylum applicants	No[c]	Yes, if granted work authorization[d]	Yes, if granted work authorization[d]

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

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

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

[128] 8 C.F.R. §236.21(c)(3).

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

[130] 22 U.S.C. §7105(b)(1).

[131] Afghans: 8 U.S.C. §1101 note; Iraqis: 8 U.S.C. §1157 note.

[132] 8 U.S.C. §1101 note.

Immigration Category	Medicaid/CHIP	ACA Health Insurance Exchanges	Medicare
COFA migrants	Yes	Yes	Yes[e]
Conditional entrants	Yes[f]	Yes	Yes
Cuban-Haitian entrants	Yes[b]	Yes	Yes
Deferred Action recipients	No	Yes	Yes
DACA recipients	No	Yes[g]	Yes[h]
DED recipients	No	Yes	Yes
Family unity beneficiaries	No[i]	Yes	Yes
Iraqi and Afghan special immigrants	Yes[b]	Yes	Yes
LPRs	Generally ineligible for five years after entry[j]	Yes	Yes
Nonimmigrants	No	Yes	Yes[e]
Refugees	Yes[b]	Yes	Yes
Parolees, granted for at least one year	Generally ineligible for five years after entry[j]	Yes	Yes
Parolees, granted for less than one year	No	Yes, with some exceptions[k]	Yes, with some exceptions[l]
Special agricultural workers in temporary resident status	No[m]	Yes	Yes
Special Immigrant Juvenile applicants	No[n]	Yes	No[n]
TPS recipients	No	Yes	Yes
TPS applicants	No	Yes, if granted work authorization	No
Ukrainian parolees	Yes[b]	Yes	Yes
VAWA self-petitioners	Generally ineligible for five years after entry[j]	Yes	Yes
Victims of human trafficking	Yes[b]	Yes	Yes
Withholding of removal grantees (INA)	Yes[b]	Yes	Yes
Withholding of removal applicants (INA)	No	Yes, if granted work authorization[o]	Yes, if granted work authorization[o]
Withholding of removal grantees (CAT)	No	Yes	No[p]
Withholding of removal applicants (CAT)	No	Yes, if granted work authorization[o]	Yes, if granted work authorization[o]
Certain noncitizens who entered the United States before January 1, 1982, in temporary resident status	No[q]	Yes	Yes

Sources: CRS analysis of the following laws and regulations: Medicaid: 8 U.S.C. §§1611, 1612(b) 1613, and 1641; ACA Health Insurance Exchanges: 42 U.S.C. §18032(a,f), 45 C.F.R. §155.20, and 45 C.F.R. §152.2; Medicare: 8 U.S.C. §1611(b)(3) and 8 C.F.R. §1.3; Afghan and Ukrainian parolees: 8 U.S.C. §1101 note; Afghan special immigrants: 8 U.S.C. §1101 note; Iraqi special immigrants: 8 U.S.C. §1157 note; victims of trafficking: 22 U.S.C. §7105(b)(1).

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. Subject to the seven-year time limit. Subsequently, they may be eligible for Medicaid at the state's option.

c. While asylum applicants are not explicitly mentioned in the Medicaid/CHIP eligibility related provisions, individuals who apply for asylum may be eligible depending on their underlying immigration status/category.

d. 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*.

e. 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 SSA, POMS, "RS 00204.025 Evidence Requirements for Establishing U.S. Lawful Presence," https://secure.ssa.gov/poms.nsf/lnx/0300204025.

f. Conditional entrants are explicitly not exempt from the five-year bar, but as they arrived in the United States before 1980, it is not applicable. (The five-year bar applies to aliens who entered the United States on or after August 22, 1996 [8 U.S.C. §1613(a)]).

g. DACA recipients were previously excluded from this definition of "lawfully present." This changed in a 2024 final rule. See HHS, CMS, "Clarifying the Eligibility of Deferred Action for Childhood Arrivals (DACA) Recipients and Certain Other Noncitizens for a Qualified Health Plan through an Exchange, Advance Payments of the Premium Tax Credit, Cost-Sharing Reductions, and a Basic Health Program," 89 *Federal Register* 39392, May 8, 2024, https://www.govinfo.gov/content/pkg/FR-2024-05-08/pdf/2024-09661.pdf.

h. DACA recipients are eligible because individuals with deferred action are eligible. 8 C.F.R. §236.21(c)(3) clarifies that DACA recipients are considered lawfully present for purposes of the provisions under 8 C.F.R. §1.3(a)(4)(vi), which concern noncitizens currently in deferred action status. (Note: 8 C.F.R. §1.3 applies to both Social Security and Medicare.) The median age of DACA recipients as of 2023 was 30; 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 DHS, USCIS, "Count of Active DACA Recipients by Age on September 30, 2023, As of June 30, 2024," https://www.uscis.gov/sites/default/files/document/data/active_daca_recipients_fy2024_q3.xlsx.

i. 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.

j. The five-year bar applies to certain qualified aliens who entered the United States on or after August 22, 1996 (8 U.S.C. §1613(a)). Some groups of qualified aliens are exempt from the five-year bar, such as refugees and asylees (8 U.S.C. §1613(b)(1)). The five-year bar does not apply to qualified aliens who have a military connection (8 U.S.C. §1613(b)(2)). The five-year bar also does not apply to LPRs who were previously in an exempt category (e.g., an individual who came to the United States as a refugee and then adjusted status to become an LPR would be exempt from the five-year bar). States may choose to cover qualified aliens within the five-year bar period and other ineligible foreign nationals (i.e., nonqualified aliens) using state-only funds for individuals, services, or both, not otherwise covered under Medicaid. In addition, states are permitted to extend Medicaid and CHIP coverage to certain "lawfully residing" children and/or pregnant women who would otherwise be eligible for coverage through these programs within the five-year bar when certain conditions are met. (CMS has broadly defined "lawfully residing" to include qualified aliens, aliens in valid nonimmigrant statuses, and many other populations, such as TPS holders and DACA recipients.) For more information, see CMS, "Medicaid and CHIP Coverage of Lawfully Residing Children & Pregnant Women," https://www.medicaid.gov/medicaid/enrollment-strategies/medicaid-and-chip-coverage-lawfully-residing-children-pregnant-individuals.

k. See 45 C.F.R. §152.2(3) for exceptions.

l. See 8 C.F.R. §1.3(a)(3)(i)-(ii) for exceptions.

m. 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.

n. 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.

o. Or if the applicant is under age 14 and has an application pending for at least 180 days.

p. 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.

q. 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 nonqualified 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."[133] Therefore, any noncitizen, regardless of immigration status, can 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*.[134] 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

[133] 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*.

[134] 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.

other care to patients with emergency conditions regardless of a patient's ability to pay;[135] therefore, they may be a source of care for uninsured individuals, including immigrants. This requirement is set forth in the Emergency Medical Treatment and 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*).[136]

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 federal tax-exempt status must meet a *community benefit standard*.[137] Some states impose similar standards for state tax exemptions or as requirements imposed on nonprofit (and in some cases, for-profit) hospitals.[138] In general, hospitals must demonstrate that they meet the community benefit standard by providing charity care or by engaging in other health promotion activities.[139] 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.[140] 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.[141] These payments offset some of a hospital's uncompensated care costs, including charity care.[142]

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[135] 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.

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

[137] 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*.

[138] 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/.

[139] 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/.

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

[141] 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.

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

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 2023, there were more than 15,500 health center delivery sites throughout the United States that provided care to more than 31 million patients; the majority of whom are uninsured or have Medicare or Medicaid.[143] 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.[144] 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.[145]

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 26.8% of patients they serve are best served in a language other than English.[146] 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. A recent survey of immigrants found that approximately 30% of those who seek care do so at a community health center.[147]

Free Clinics

There are more than 1,400 free clinics that provide care at free or reduced rates.[148] The services provided vary by clinic. Primary care services and health education are the most common services they provide, followed by referrals and pharmacy.[149] The federal government does not provide direct support for these facilities. As such, it does not require that free clinics provide a

[143] HHS, Health Resources and Services Administration (HRSA), *Health Center Program, 2023 Uniform Data System Trends, Data Brief, August 2024*, https://bphc.hrsa.gov/sites/default/files/bphc/data-reporting/2023-uds-trends-data-brief.pdf.

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

[145] Mabel C. Ezeonwu, "Specialty-Care Access for Community Health Clinic Patients; Processes and Barriers," *Journal of Multidisciplinary Healthcare*, vol. 11 (February 22, 2018), pp. 109-119.

[146] 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=2023.

[147] Drishti Pillai et al., *Health and Health Care Experiences of immigrants: The 2023 KFF/LA Times Survey of Immigrants*, KFF, September 17, 2023, https://www.kff.org/racial-equity-and-health-policy/issue-brief/health-and-health-care-experiences-of-immigrants-the-2023-kff-la-times-survey-of-immigrants/.

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

[149] The National Association of Free & Charitable Clinics: "Free and Charitable Clinics and Pharmacies-2024 Fact Sheet," https://nafcclinics.org/wp-content/uploads/2024/03/NAFC-FACT-SHEET-2024.pdf.

specific set of services.[150] The National Association of Free & Charitable Clinics provides some data on free clinics from 2023. It found that free clinics served 1.7 million patients, who had 5.7 million patient visits. It also reported that 82% of the patients served were uninsured, but it did not report data on immigration status.[151]

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

HHS' Title X program provides grants to public and nonprofit agencies to provide family planning services to individuals regardless of their ability to pay.[152] Facilities use a sliding scale fee schedule.[153] 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).[154] 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

[150] 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, FY2025*, https://www.hrsa.gov/sites/default/files/hrsa/about/budget/budget-justification-fy2025.pdf, pp. 80-82. 248 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/.

[151] The National Association of Free & Charitable Clinics, "Free and Charitable Clinics and Pharmacies-2024 Fact Sheet," https://nafcclinics.org/wp-content/uploads/2024/03/NAFC-FACT-SHEET-2024.pdf.

[152] 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.

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

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

program considers the individual's HIV status and income; it does not use immigration status in this determination.[155] 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.[156]

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;
- 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;[157] 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.[158]

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 2022 survey of local health departments found that 88% reported providing childhood immunizations, 87% reported providing adult immunizations, nearly two-thirds provided screening for sexually transmitted diseases, and 58% provided HIV/AIDS testing. Smaller

[155] 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.

[156] HIV.gov, "What is the Ending the HIV Epidemic in America," https://www.hiv.gov/federal-response/ending-the-hiv-epidemic/overview.

[157] 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*.

[158] 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*.

percentages of local health departments provided health services such as treatment for communicable diseases, well-child clinics, and prenatal care.[159]

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.[160] 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.

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," which include medical treatment and health care facilities.[161] 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.[162]

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)).[163] The INA does not define the term *public charge*.[164] Thus, the determination of whether an alien is

[159] National Association of County and City Health Officials, *2022 National Profile of Local Health Departments*, Chapter 7, "Programs and Services, Clinical programs and services provided directly in the past year," Figure 7.1, p. 68, https://www.naccho.org/uploads/downloadable-resources/NACCHO-2022-Profile-Report.pdf.

[160] 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.

[161] DHS, 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.

[162] 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; 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.

[163] 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.

[164] 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*.

inadmissible[165] on public charge grounds turns largely on standards set forth in agency guidance.[166]

From 1999 to 2019, agency guidance[167] 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.[168] 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.[169] Thus, on March 9, 2021, the agency reverted back to the 1999 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.[170]

While the 2019 rule was in effect, it appears to have had an effect on immigrants' use of public benefits, including health care services.[171] 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).[172] 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.[173] A 2023 survey of immigrants found that 58% of respondents were "not sure" whether the use of public benefits decreases one's likelihood of being approved for a green card, while 16% incorrectly believe it does decrease

[165] "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. For more information, see CRS In Focus IF12662, *Immigration: Grounds of Inadmissibility*.

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

[167] 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.

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

[169] For more information, see DHS, USCIS, "Inadmissibility on Public Charge Grounds Final Rule: Litigation," https://www.uscis.gov/green-card/green-card-processes-and-procedures/public-charge/inadmissibility-on-public-charge-grounds-final-rule-litigation.

[170] 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*.

[171] 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/.

[172] 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/.

[173] 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.

one's chances.[174] These figures were higher (68% and 22%, respectively) among immigrants the survey classified as likely to be unauthorized.[175]

[174] Drishti Pillai et al., *Health and Health Care Experiences of Immigrants: The 2023 KFF/LA Times Survey of Immigrants*, KFF, September 17, 2023, https://www.kff.org/racial-equity-and-health-policy/issue-brief/health-and-health-care-experiences-of-immigrants-the-2023-kff-la-times-survey-of-immigrants/.

[175] Ibid.

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
CMS	Centers for Medicare & Medicaid Services
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 Labor Act
FAP	Financial Assistance Policy
FMTPB	Federal Means-tested Public Benefits
HHS	Health and Human Services
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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