MPI
MIGRATION POLICY INSTITUTE

Immigrant Children's Medicaid and CHIP Access and Participation

A Data Profile

POLICY BRIEF

JUNE 2022

BY VALERIE LACARTE

Executive Summary

Poor health in childhood can have lifelong implications, having been linked to poorer health and higher medical costs in adulthood. Many immigrant children in the United States face additional hurdles to staying healthy, including a higher likelihood of being in a low-income household and a federal law that limits their access to comprehensive health insurance. In 2019, close to 2.3 million foreign-born children ages 0 to 18 met the income-based eligibility requirements for Medicaid and the Children's Health Insurance Program (CHIP), but 646,000 of these children were uninsured. An estimated 909,000 of the 2.3 million income-eligible immigrant children—40 percent—were barred from accessing Medicaid or CHIP due to their immigration status (unauthorized immigrants, lawful permanent residents with fewer than five years in that status, and certain other lawfully present immigrants). These income-eligible children with immigration statuses that made them federally ineligible for these programs had an uninsured rate of 43 percent—more than seven times the rate among U.S.-born children (6 percent). Even those income-eligible immigrant children who were not barred from these federal programs had a relatively high uninsured rate of 18 percent. Higher poverty rates and lower private coverage from parents' employers and other sources likely also contributed to these higher uninsured rates among immigrant children.

While federal rules under the 1996 *Personal Responsibility and Work Opportunity Reconciliation Act* (PRWORA) bar many noncitizen children from public health insurance, some states have filled the gap by adopting a federal option to extend coverage to additional groups, by using state funding, or both. In 2009, through the *Children's Health Insurance Program Reauthorization Act* (CHIPRA), Congress authorized states to use federal funds to cover Medicaid and CHIP for a greater range of lawfully present immigrant children. It is up to states to decide whether to take this option. To date, 34 states and the District of Columbia have done so. As of June 2022, the District of Columbia and six states—California, Illinois, Massachusetts, New York, Oregon, and Washington—had gone further by enacting state-funded programs to cover unauthorized immigrant children. Four other states (Connecticut, Maine, New Jersey, and Vermont) have adopted legislation that will soon cover certain groups of unauthorized immigrant children.

An estimated 909,000 of the 2.3 million income-eligible immigrant children—40 percent—were barred from accessing Medicaid or CHIP due to their immigration status.

Yet even when immigrant children are eligible for Medicaid and CHIP on both income and immigration-status grounds, they are less likely than U.S.-born children in families with similar incomes to participate in these programs. As of 2019, 74 percent of federally eligible immigrant children were enrolled versus 92 percent of U.S.-born children. This held true within all racial and ethnic categories. The largest immigrant–native gap in Medicaid and CHIP coverage was among Latino children, with a participation rate of 92 percent for U.S.-born Latino children compared to 64 percent for federally eligible Latino immigrant children.

The CHIPRA option has been effective in improving the coverage of immigrant children, both by expanding their eligibility and by encouraging participation among those who are eligible. In 2019, 64 percent of income-eligible immigrant children living in CHIPRA states were federally eligible (this includes all lawfully residing children), versus 35 percent of those in non-CHIPRA states. The participation rate of federally eligible immigrant children was 74 percent in CHIPRA states compared to 68 percent in non-CHIPRA states. The four states with the highest participation rates for federally eligible immigrant children were all CHIPRA states: Massachusetts, New York, Michigan, and Washington.

The data analyzed in this brief reflect the state of immigrant children's eligibility and coverage in 2019, before the Biden administration and the COVID-19 pandemic began. Subsequent policy changes, including a shift in enforcement priorities resulting in a drop in immigrant arrests and the termination of the public-charge rule that created immigration consequences for noncitizens who participated (or were deemed likely to participate) in an expanded list of public benefits programs may have eased concerns in some immigrant families about enrolling their eligible children in Medicaid and CHIP. Meanwhile, the pandemic has greatly increased the need for health coverage while reducing private coverage in families where adults have lost their jobs. Despite these changes, hundreds of thousands of children remain barred from public health coverage due to their immigration status, with many in mixed-status families that hesitate to participate in government programs. Gaps in coverage may set back the health and development of immigrant children, leading to potentially reduced quality of life or lower life expectancy, costly medical conditions, and lower productivity during adulthood.

1 Introduction

A child's access to health care can have a long-term impact, with poor health in childhood linked to health complications and higher medical costs in adulthood. Many immigrant children, who are more likely than their U.S.-born peers to live in low-income households, face additional hurdles to staying healthy because federal law limits their access to comprehensive public health insurance.[1]

The Children's Health Insurance Program (CHIP) was created through the *Balanced Budget Act of 1997* and expanded by the *Affordable Care Act of 2010* (ACA).[2] As a complement to Medicaid, CHIP provides healthcare coverage to uninsured children under age 19 whose families' income is above Medicaid maximum income limits but below a certain percentage of the federal poverty level (FPL), as determined by their state of residence.[3] States have flexibility in the way they administer Medicaid and CHIP funds and, more importantly, in setting income requirements, thereby increasing or decreasing the number of low-income children eligible for Medicaid and CHIP.[4] Foreign-born children may face additional federal eligibility restrictions depending on their immigration status, as a result of the 1996 *Personal Responsibility and Work Opportunity Reconciliation Act* (PRWORA).[5]

PRWORA introduced multiple restrictions on noncitizens' eligibility for a broad range of public benefits, including Medicaid and extended to CHIP when it was enacted in 1997.[6] Under PRWORA, certain non-

citizens are totally ineligible for federally funded nonemergency Medicaid and CHIP, including all immigrants without lawful status, many with temporary status, and most lawful permanent residents (LPRs, also known as green-card holders) during their first five years in that status. There are some exceptions to these bars, including for refugees, asylees, and some immigrants with other, mostly humanitarian statuses (see Table 1).

TABLE 1

Noncitizen Children's Eligibility for Medicaid and the Children's Health Insurance Program

Eligible without a Five-Year Bar	Eligible but Subject to Five-Year Bar	Ineligible Immigrants Unless eligible under the *Children's Health Insurance Program Reauthorization Act* (CHIPRA)
• Refugees • Asylees • Cuban/Haitian entrants • Amerasians • Victims of trafficking • Iraqi or Afghan Special Immigrant Visa (SIV) holders • Withholding of removal grantees • Veterans; active duty military members; and their spouses, unremarried surviving spouses, and children • Children and youth up to age 21 who are lawfully residing in the United States, if state elected CHIPRA option • Supplemental Security Income (SSI) recipients • Citizens of Palau, Micronesia, and the Marshall Islands who lawfully reside in the United States under the Compacts of Free Association (COFA)* • Pregnant people who are lawfully residing in the United States, if state elected the CHIPRA option • Afghan parolees paroled into the United States through Operation Allies Welcome	• Certain LPRs who are under age 21 and/or pregnant, if state did not elect the CHIPRA option** • Parolees, if paroled into the United States for one year or longer • Certain domestic violence survivors, including *Violence Against Women Act* (VAWA) self-petitioners	• Unauthorized immigrants • Deferred Action for Childhood Arrivals (DACA) beneficiaries **Eligible in CHIPRA states:** • Others granted deferred action • Nonimmigrant visa holders, including U-visa holders*** • Temporary Protected Status (TPS) beneficiaries • Certain asylum seekers • Certain holders of employment-based and student temporary visas • Other lawfully residing individuals listed in Title 45 of the *Code of Federal Regulations*, Section 152.2

* Entrants under COFA are permitted to study, reside, and work in the United States indefinitely, but are not LPRs.
** The five-year bar does not apply to LPRs who adjusted status from an exempt group such as refugees and asylees.
*** The U nonimmigrant status (U visa) is for victims of certain crimes who are helpful to law enforcement or government officials in the investigation or prosecution of criminal activity.
Sources: U.S. Citizenship and Immigration Services (USCIS), "Derivative Refugee/Asylum Status for Your Children," updated July 9, 2020; Karina Fortuny and Ajay Chaudry, "Overview of Immigrants' Eligibility for SNAP, TANF, Medicaid, and CHIP" (issue brief, U.S. Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation, Washington, DC, March 2012), 9–10; Emily McCabe and Leslye E. Orloff, "Comparison Chart of VAWA and U Visa Immigrant Relief" (chart, National Immigrant Women's Advocacy Project, American University, Washington College of Law, June 20, 2014); USCIS, "Victims of Criminal Activity: U Nonimmigrant Status," updated June 12, 2018; Claire R. Thomas and Ernie Collette, "Barring Survivors of Domestic Violence from Food Security: The Unintended Consequences of 1996 Welfare and Immigration Reform," *Drexel Law Review* 9 (2017): 379–380; Centers for Medicare and Medicaid Services, "Medicaid and CHIP Coverage of 'Lawfully Residing' Children and Pregnant Women" (state health official letter no. 10–006, July 1, 2010). For a full list of lawfully residing individuals, see *45 Code of Federal Regulations* §152.2.

This policy brief examines federal eligibility for and participation in Medicaid and CHIP by foreign-born children ages 0 to 18. It follows a similar Migration Policy Institute publication focused on Medicaid eligibility and participation among immigrant adults ages 19 to 64.[7] This analysis presents estimates of the number of immigrant children who have incomes low enough to qualify for Medicaid and CHIP, and among them, the number who are either federally eligible or ineligible due to their immigration status under the categories set out in PRWORA. The brief also describes Medicaid and CHIP participation and uninsured rates among U.S.-born and federally eligible immigrant children at the national and state levels and by their race and ethnicity.

CHIPRA Option and State Discretion

CHIP was initially enacted for a limited time but has been incrementally extended since 2009, with Congress most recently reauthorizing the program through January 2028.[8] When reauthorizing CHIP in the *Children's Health Insurance Program Reauthorization Act of 2009* (CHIPRA), Congress allowed states to extend coverage to certain green-card holders during the time when they would otherwise face the five-year bar, and to certain other lawfully present immigrants: Medicaid coverage for those who are pregnant, CHIP for children and youth up to age 19, and Medicaid for those up to age 21.[9]

Lawfully residing immigrants who are not federally eligible for Medicaid and CHIP can become eligible when a state opts to extend coverage under CHIPRA. In states that take this CHIPRA option, these immigrants include LPRs during their first five years in that status, persons with temporary statuses (such as Temporary Protected Status and Deferred Enforced Departure), and certain asylum seekers, but not unauthorized immigrants and persons granted relief under the Deferred Action for Childhood Arrivals (DACA) program. As of June 2022, 34 states and the District of Columbia had extended Medicaid and CHIP coverage to lawfully residing children without the five-year wait.[10]

Federal dollars cannot be used to fund coverage for unauthorized immigrant populations. However, the District of Columbia and six states—California, Illinois, Massachusetts, New York, Oregon, and Washington—administer and fund their own programs without federal support (see Box 1) to cover income-eligible unauthorized immigrant children (in addition, Washington, DC covers unauthorized immigrant adults of all ages, and California covers young unauthorized immigrant adults ages 19 to 25 and, since May 1, 2022, also covers adults ages 50 to 64).[11]

The District of Columbia and six states—California, Illinois, Massachusetts, New York, Oregon, and Washington—administer and fund their own programs without federal support ... to cover income-eligible unauthorized immigrant children.

BOX 1
State Replacement Programs Extending Medicaid- and CHIP-Equivalent Coverage to Income-Eligible Unauthorized Immigrant Children

As of June 2022, the District of Columbia and six states had gone beyond simply taking the CHIPRA option with measures to ensure that all children have access to comprehensive and affordable health insurance. By funding their own Medicaid- and CHIP-equivalent programs, they extend health insurance coverage to all income-eligible children, including unauthorized immigrant children barred from federally funded Medicaid and CHIP.

- In **California**, income-eligible children under age 19 are eligible for full-scope Medi-Cal and so are young adults between ages 19 and 25, though their maximum family income threshold is lower than that of children (138 percent compared to 266 percent of the FPL).
- In the **District of Columbia**, the Immigrant Children's Health Program provides health-care coverage to all children below the age of 21 with a family income below 200 percent of the FPL.
- In **Illinois**, the state-funded program All Kids provides free or affordable health-care coverage to children up to age 18 with a family income below 300 percent of the FPL.
- In **Massachusetts**, the Children's Medical Security Plan provides coverage for primary and preventive medical and dental services to uninsured children who do not qualify for any other type of MassHealth coverage.
- In **New York**, income-eligible unauthorized immigrant children are eligible for Child Health Plus B.
- In **Oregon**, the Oregon Health Plan (Cover All Kids) is open to all income-eligible children under age 19, regardless of immigration status.
- In **Washington**, state-funded Apple Health for Kids covers all children whose immigration status makes them ineligible for federal medical coverage.

While they have yet to be implemented, state-funded replacement programs in Connecticut, Maine, New Jersey, and Vermont will soon extend coverage to some unauthorized immigrant children in those states. Other states extend coverage to certain federally ineligible populations—for example in Minnesota, state-funded MinnesotaCare is available for DACA recipients—but they are not as inclusive of all immigrant children as the programs described above.

Sources: For California: SB 75 covers children of any immigration status under 19, providing full Medi-Cal coverage; see State of California, "SB-75 Health," June 24, 2015. SB 104 provides full coverage for adults ages 19–25 inclusive, providing full Medi-Cal coverage; see State of California, "SB-104 Health," July 9, 2019. For Washington, DC: District of Columbia, "District of Columbia Medical Assistance Program," *Code of the District of Columbia* §1-307.02.02, May 18, 2020. For Illinois: Illinois Department of Healthcare and Family Services, "About All Kids," accessed June 17, 2021. Co-pays and premiums may be required based on income. Illinois General Assembly, *Covering All Kids Health Insurance Act*, 215 ILCS 170/63, effective July 1, 2006. For Massachusetts: State of Massachusetts, "Children's Medical Security Plan (CMSP)," 130 Mass. Reg. 522.004. Legislation establishing the plan was passed in 1993. For New York: New York Government, "Documentation Guide. Immigrant Eligibility for Health Coverage in New York State" (guidance document, 2004). For Oregon: Oregon Senate, *Relating to Improving the Health of Oregon Children; and Declaring an Emergency*, Senate Bill 558 (2017), Chapter 652. For Washington: Washington State Healthcare Authority, "Washington Apple Health" (fact sheet, 2022); Washington LawHelp, "Apple Health for Kids Program: Responding to DSHS Requests for Immigration and Citizenship Documents," updated April 11, 2019; Washington State Legislature, *All Kids Bill*, Senate Bill 5093, signed March 2007. For Minnesota: Minnesota House Research, "Eligibility of Noncitizens for Health Care and Cash Assistance Programs" (brief, November 2019); Minnesota Department of Human Services, "Minnesota Health Care Programs Eligibility Policy Manual," Section 2.5.2 and Section 3.2.1.2, published June 1, 2020. See also National Immigration Law Center, "Table 3: Medical Assistance Programs for Immigrants in Various States," updated July 2021.

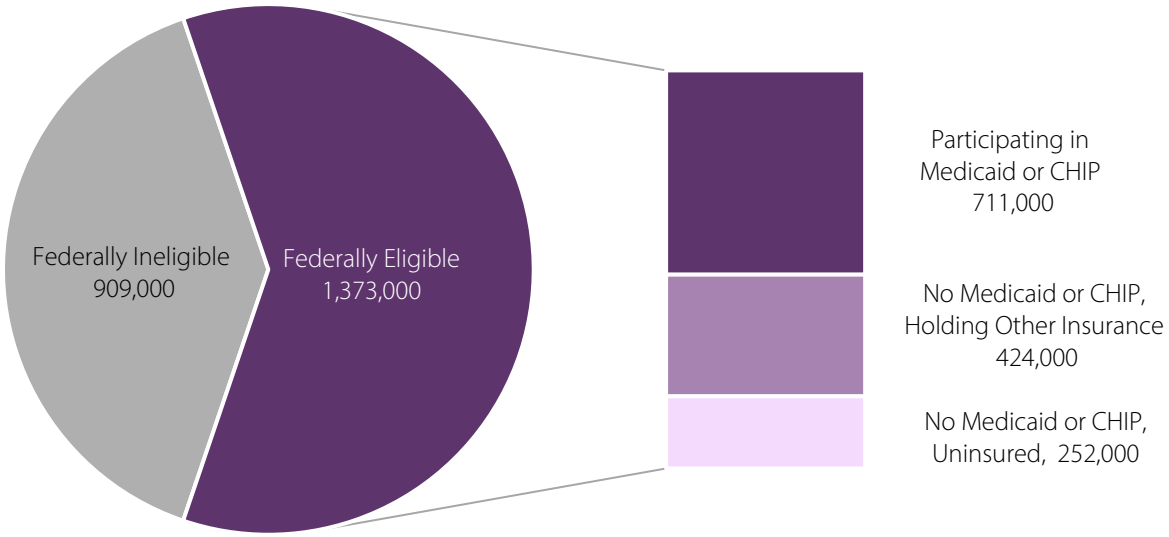
2 Federal Eligibility of Income-Eligible Children

Based on analysis of data from the U.S. Census Bureau's American Community Survey (ACS), the Migration Policy Institute estimates that close to 2.3 million foreign-born children ages 0 to 18 were income eligible for Medicaid and CHIP in 2019 based on the maximum family income thresholds set by their states of residence (see Box 2 for definitions of income and federal eligibility). Approximately 1.4 million (60 percent) of these children held an immigration status that made them eligible for Medicaid and CHIP (see Figure 1). The other 40 percent, about 909,000 income-eligible immigrant children, were ineligible for federally funded Medicaid and CHIP due to their immigration status.

Of the immigrant children who were federally eligible for Medicaid or CHIP, about half, or 711,000, were participating in these programs. Another 424,000 held some other form of health insurance, mostly private coverage through their parents' employers. For these children, health coverage depends on the quality and stability of their parents' employment. Yet as the pandemic has illustrated, low-income immigrants are disproportionately employed in industries that are vulnerable to economic fluctuations, and therefore are also vulnerable to loss of insurance coverage.[12] Finally, an estimated 252,000 immigrant children who were federally eligible for Medicaid and CHIP were uninsured (see Section 4 for further information on uninsured children).

FIGURE 1

Estimated Medicaid and CHIP Income-Eligible Foreign-Born Children (ages 0–18), by Federal Immigration-Status Eligibility and Participation, United States, 2019



Note: Numbers may not add up to the total due to rounding. The federally eligible population includes all lawfully residing children in states that adopted the CHIPRA option (see Table 1 and Box 2 for definitions of federally eligible and ineligible children). Other insurance includes public coverage other than Medicaid, Department of Veterans Affairs insurance, and private insurance. Based on U.S. Census Bureau definitions, private insurance can include employer-sponsored coverage, plans purchased by individuals from private insurance companies, TRICARE, or other military health-care coverage.
Source: These 2019 data result from Migration Policy Institute (MPI) analysis of data from the 2015–19 American Community Survey (ACS), pooled, and the 2008 Survey of Income and Program Participation (SIPP), weighted to 2019 unauthorized immigrant population estimates provided by Jennifer Van Hook at The Pennsylvania State University.

BOX 2
Determination of Income Eligibility and Federal Eligibility

While many studies on immigrants' use of public benefits focus on contrasts between immigrant and native-born participation, this brief goes a step further using a set of techniques to disaggregate outcomes by immigrants' federal eligibility status. To determine if a child ages 0 to 18 is income eligible for Medicaid/CHIP, the author uses state-level maximum income limits and income determination rules based on reconstructed family units and adjusted gross income, as described in MPI's 2021 policy brief *Medicaid Access and Participation: A Data Profile of Eligible and Ineligible Immigrant Adults*.

To impute immigration status and identify federally eligible and ineligible immigrants under PRWORA, the author used data from the 2015–19 American Community Survey (ACS), pooled, and the 2008 Survey of Income and Program Participation (SIPP). The methodology used allows for the identification of the most important immigration statuses described in Table 1: lawful permanent residents (with and without five years of U.S. residence), nonimmigrants, unauthorized immigrants, refugees, asylees, and Cuban/Haitian entrants. Other smaller categories cannot be captured.

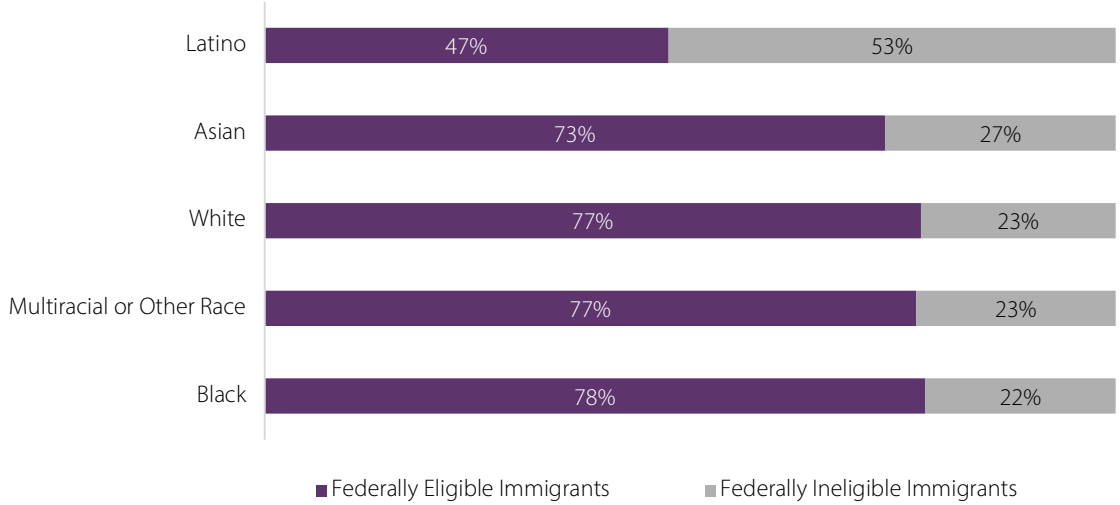
Which immigration statuses fall under the definition of "federally eligible" vary depending on whether a state has elected the CHIPRA option. In states that have adopted CHIPRA, all lawfully present foreign-born children ages 0 to 18 are considered to have a status that makes them federally eligible. In states that have not adopted CHIPRA, federally eligible children include: naturalized citizens, LPRs with more than five years of residence, refugees, and those with other, similar humanitarian statuses. The federally ineligible immigrant population includes unauthorized immigrant children (as well as those with DACA) in all states, and in states that have not adopted CHIPRA, it includes nonrefugee LPRs with fewer than five years of U.S. residence and nonrefugee holders of nonimmigrant visas.

One challenging aspect of this type of analysis is estimating the number and participation rate of children in quasi-legal immigration statuses, such as TPS holders, who are eligible for Medicaid and CHIP in states that have adopted CHIPRA. In this analysis, these children appear within the federally ineligible population and their participation rate could not be estimated. Though a share of these children were likely income eligible and living in a state that gave them access to federally funded Medicaid and CHIP through CHIPRA, these numbers are unlikely to change the general trends found in this analysis.

Sources: For a discussion of the methodology to determine eligibility based on income and on immigration status, see Box 1 of Valerie Lacarte, Mark Greenberg, and Randy Capps, *Medicaid Access and Participation: A Data Profile of Eligible and Ineligible Immigrant Adults* (Washington, DC: MPI, 2021). For information on the state maximum income thresholds to access Medicaid/CHIP, see Kaiser Family Foundation, "Medicaid and CHIP Income Eligibility Limits for Children as a Percent of the Federal Poverty Level," accessed March 17, 2022.

FIGURE 2

Shares of Medicaid and CHIP Income-Eligible Foreign-Born Children (ages 0–18) Who Were Federally Eligible and Ineligible, by Race and Ethnicity, United States, 2019



Notes: In this figure all racial/ethnic categories are mutually exclusive, and all Latinos are included in that category regardless of their race. "Multiracial or other race" includes respondents who self-identified with more than one race or selected another race not listed in the ACS. Native Americans are excluded from this analysis due to small sample size. The federally eligible population includes all lawfully residing children in states that adopted the CHIPRA option (see Table 1 and Box 2 for definitions of federally eligible and ineligible children).
Source: These 2019 data result from MPI analysis of data from the 2015–19 ACS, pooled, and the 2008 SIPP, weighted to 2019 unauthorized immigrant population estimates provided by Van Hook.

A. *Race and Ethnicity of Income-Eligible Immigrant Children*

More than half of the 2.3 million income-eligible immigrant children in 2019 were Latino (of any race), representing 1.2 million children ages 0 to 18. Asian children comprised the second largest racial/ethnic group, representing 20 percent of all income-eligible foreign-born children (466,000 children). Black and White immigrant children represented 12 percent and 11 percent of all income-eligible immigrant children, respectively.[13] The top ten countries of origin for income-eligible immigrant children were: Mexico, El Salvador, Guatemala, China, Honduras, the Dominican Republic, the Philippines, India, Venezuela, and Vietnam.

The share of these income-eligible children who were ineligible for Medicaid and CHIP due to their immigration status varied considerably by race and ethnicity, with an estimated 53 percent of Latino immigrant children federally ineligible in 2019 (see Figure 2). Their share was twice as high as that for Asian (27 percent), White (23 percent), Multiracial or other race (23 percent), and Black (22 percent) income-eligible immigrant children.

B. *State-by-State Estimates of Income-Eligible Immigrant Children*

In 2019, the number and share of foreign-born children who were income eligible for Medicaid and CHIP varied by state, as did the share who were eligible for federally funded coverage under these programs based on their immigration statuses (see Table 2). Notable trends include:

- About 88 percent of income-eligible immigrant children lived in one of the

34 states or the District of Columbia that chose to expand eligibility for public health insurance by adopting the CHIPRA option. On average, 64 percent of income-eligible immigrant children in CHIPRA states were federally eligible for Medicaid and CHIP based on their immigration status, compared to only 35 percent in non-CHIPRA states.

- In states that adopted the CHIPRA option, an estimated 40 percent of federally eligible immigrant children were LPRs with fewer than five years in that status and 7 percent were holders of nonimmigrant visas, meaning that nearly half of federally eligible immigrant children in those states were lawfully present but would not have had access to coverage if their state had not taken the CHIPRA option.
- The three states with the largest populations of foreign-born children ages 0 to 18 with incomes low enough to qualify for Medicaid and CHIP were: California, Texas, and New York. Although all three of these states have adopted the CHIPRA option, the shares of immigrant children who were federally eligible for Medicaid and CHIP in California and Texas (59 percent and 52 percent, respectively) were significantly lower than the share in New York (74 percent). This reflects the fact that California and Texas had among the highest shares of income-eligible immigrant children who were not lawfully present in the country (41 percent and 48 percent, respectively) compared to 26 percent in New York.
- The states with the highest shares of federally eligible immigrant children were: Minnesota, Iowa, Nebraska, Ohio, Wisconsin, New York, Pennsylvania, Massachusetts, and Hawaii. These states had all elected the CHIPRA option and, compared to other states, their foreign-born child populations generally had lower shares of unauthorized immigrants and higher shares of LPRs with more than five years in that status and other immigrants in groups eligible for coverage under PRWORA, such as refugees. All except New York also had relatively small populations of income-eligible immigrant children.[14]
- States with the lowest shares of income-eligible immigrant children who were federally eligible for Medicaid and CHIP were all states that have not adopted the CHIPRA option: Mississippi, Tennessee, Kansas, Alabama, Oklahoma, Georgia, Arizona, and Indiana. In these states, unauthorized immigrants made up relatively large shares of the income-eligible immigrant population.[15]

TABLE 2

Estimated Medicaid and CHIP Income-Eligible Children (ages 0–18), by Nativity and Federal Eligibility, 50 States and District of Columbia, 2019

	Income-Eligible U.S.-Born Children	Income-Eligible Foreign-Born Children				
		Total	Federally Eligible for Medicaid and CHIP		Federally Ineligible for Medicaid and CHIP	
	Number	*Number*	*Number*	*Share of Total*	*Number*	*Share of Total*
Alabama	810,000	13,000	4,000	30%	9,000	70%
Alaska	97,000	3,000	-	-	-	-
Arizona	861,000	43,000	15,000	35%	28,000	65%
Arkansas*	444,000	11,000	5,000	47%	6,000	53%
California**	5,479,000	418,000	247,000	59%	171,000	41%
Colorado*	647,000	31,000	20,000	64%	11,000	36%
Connecticut*	380,000	26,000	18,000	68%	8,000	32%
Delaware*	101,000	5,000	-	-	-	-
District of Columbia**	77,000	5,000	-	-	-	-
Florida*	2,311,000	215,000	144,000	67%	70,000	33%
Georgia	1,588,000	63,000	21,000	34%	41,000	66%
Hawaii*	198,000	15,000	11,000	71%	4,000	29%
Idaho	213,000	5,000	2,000	44%	3,000	56%
Illinois**	1,813,000	73,000	48,000	66%	25,000	34%
Indiana	952,000	27,000	9,000	35%	17,000	65%
Iowa*	506,000	13,000	10,000	77%	3,000	23%
Kansas	381,000	16,000	5,000	30%	11,000	70%
Kentucky*	582,000	15,000	10,000	67%	5,000	33%
Louisiana*	721,000	15,000	8,000	52%	7,000	48%
Maine*	117,000	3,000	-	-	-	-
Maryland*	714,000	56,000	35,000	63%	21,000	37%
Massachusetts**	631,000	64,000	46,000	72%	18,000	28%
Michigan	1,118,000	34,000	14,000	42%	20,000	58%
Minnesota*	627,000	36,000	29,000	82%	7,000	18%
Mississippi	466,000	5,000	1,000	25%	4,000	75%
Missouri	912,000	18,000	7,000	40%	11,000	60%
Montana*	136,000	-	-	-	-	-
Nebraska*	217,000	12,000	9,000	75%	3,000	25%
Nevada*	375,000	23,000	14,000	58%	10,000	42%
New Hampshire	131,000	5,000	2,000	44%	3,000	56%
New Jersey*	1,063,000	100,000	65,000	65%	35,000	35%
New Mexico*	373,000	12,000	7,000	58%	5,000	42%

TABLE 2 (cont.)

Estimated Medicaid and CHIP Income-Eligible Children (ages 0–18), by Nativity and Federal Eligibility, 50 States and District of Columbia, 2019

	Income-Eligible U.S.-Born Children	Income-Eligible Foreign-Born Children				
		Total	Federally Eligible for Medicaid and CHIP		Federally Ineligible for Medicaid and CHIP	
	Number	*Number*	*Number*	*Share of Total*	*Number*	*Share of Total*
New York**	2,855,000	227,000	169,000	74%	58,000	26%
North Carolina*	1,311,000	54,000	30,000	56%	23,000	44%
North Dakota	54,000	-	-	-	-	-
Ohio*	1,327,000	31,000	23,000	76%	7,000	24%
Oklahoma	553,000	17,000	5,000	33%	11,000	67%
Oregon**	552,000	21,000	14,000	66%	7,000	34%
Pennsylvania*	1,664,000	56,000	41,000	73%	15,000	27%
Rhode Island*	108,000	8,000	-	-	-	-
South Carolina*	643,000	18,000	10,000	53%	8,000	47%
South Dakota	96,000	3,000	-	-	-	-
Tennessee	971,000	32,000	9,000	28%	23,000	72%
Texas*	4,047,000	288,000	151,000	52%	138,000	48%
Utah*	381,000	16,000	9,000	56%	7,000	44%
Vermont*	69,000	2,000	-	-	-	-
Virginia*	760,000	48,000	30,000	61%	19,000	39%
Washington**	984,000	59,000	39,000	66%	20,000	34%
West Virginia*	272,000	1,000	-	-	-	-
Wisconsin*	755,000	17,000	13,000	75%	4,000	25%
Wyoming	58,000	-	-	-	-	-
U.S. Total	**42,501,000**	**2,282,000**	**1,373,000**	**60%**	**909,000**	**40%**

* States that have adopted the CHIPRA option.

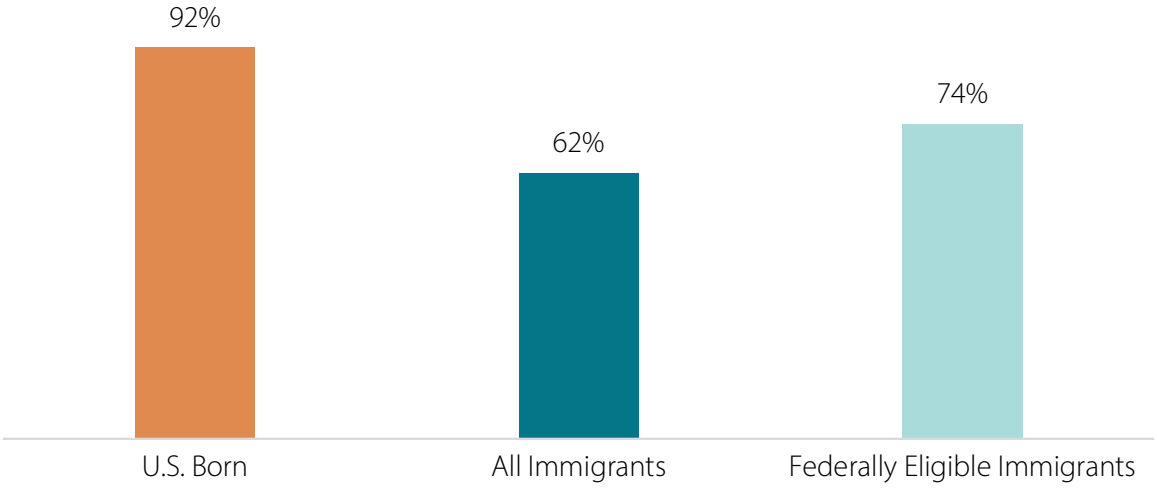
** States that have adopted CHIPRA and also have state-funded programs that cover unauthorized immigrant children.

Notes: Numbers may not add up to the total due to rounding. Categories marked "-" have a sample size too small to generate statistically meaningful results. This analysis uses a simplified set of immigration statuses to estimate the federally eligible foreign-born population in non-CHIPRA states: naturalized U.S. citizens, lawful permanent residents (LPRs) with more than five years in that status, refugees, asylees, Haitian/Cuban entrants, and Iraqi and Afghan Special Immigrant Visa (SIV) holders. In CHIPRA states, the federally eligible population includes all immigrant children of all statuses except unauthorized immigrants. Other specific statuses shown in Table 1 could not be captured due to data limitations. The federally ineligible population in CHIPRA states includes only unauthorized immigrant children (as well as those with DACA); in non-CHIPRA states, it also includes nonrefugee LPRs with fewer than five years in that status; holders of temporary nonimmigrant visas such as international students, H-1B high-skilled temporary workers, and H-2A agricultural workers; TPS beneficiaries; and asylum seekers. LPRs who had held that status for at least five years could not be modeled, so those with at least five years of total U.S. residence were used as a proxy. Determination of the federal poverty level (FPL) is based on the author's computation of family to poverty ratio to account for adjusted gross income and poverty guidelines set by the U.S. Department of Health and Human Services (HHS).

Sources: These 2019 data result from MPI analysis of data from the 2015–19 ACS, pooled, and the 2008 SIPP, weighted to 2019 unauthorized immigrant population estimates provided by Van Hook.

FIGURE 3

Medicaid and CHIP Participation Rates among Income-Eligible Children (ages 0–18), by Nativity and Federal Eligibility, United States, 2019



Note: The federally eligible population includes all lawfully residing children in states that adopted CHIPRA (see Table 1 and Box 2 for definitions of federally eligible and ineligible children).
Source: These 2019 data result from MPI analysis of data from the 2015–19 ACS, pooled, and the 2008 SIPP, weighted to 2019 unauthorized immigrant population estimates provided by Van Hook.

3 Medicaid and CHIP Participation Rates

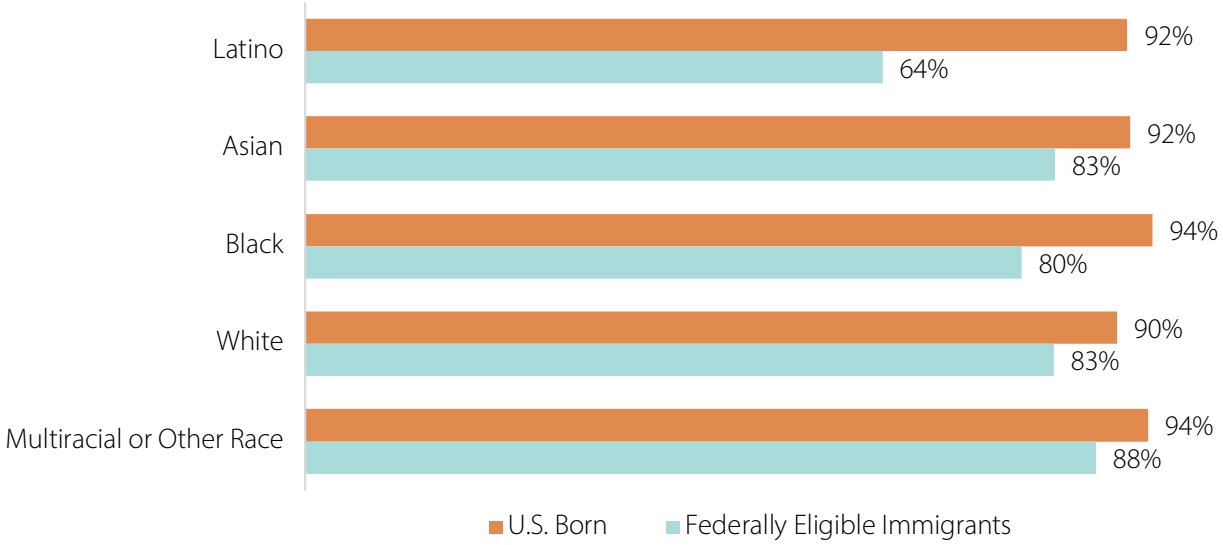
Even when they are eligible on both income and immigration-status grounds, immigrant children are much less likely to participate in Medicaid or CHIP than U.S.-born children. Nationwide, 92 percent of U.S.-born children who were income eligible participated in Medicaid and CHIP in 2019, once those with private or other insurance coverage were excluded from the calculation (see Figure 3). By contrast, only 62 percent of all income-eligible immigrant children—and 74 percent of those who were federally eligible based on immigration status—participated.

A. Participation Rates by Race and Ethnicity

Across all major racial and ethnic groups, foreign-born income-eligible children with immigration statuses that make them federally eligible for Medicaid and CHIP are less likely to participate in these programs than U.S.-born children. Medicaid and CHIP participation rates were 90 percent or higher for income-eligible U.S.-born children in every major racial/ethnic group (see Figure 4). Participation was substantially lower for federally eligible immigrant children in every group, with the widest gap for Latinos (64 percent versus 92 percent) and the smallest gap for children who identified as multiracial (88 percent versus 94 percent).

FIGURE 4

Medicaid and CHIP Participation Rates among Income-Eligible U.S.-Born and Federally Eligible Immigrant Children (ages 0–18), by Race and Ethnicity, United States, 2019



Notes: In this figure, all racial/ethnic categories are mutually exclusive, and all Latinos are included in that category regardless of their race. "Multiracial or other race" includes respondents who self-identified with more than one race or selected another race not listed in the ACS. Native Americans are excluded from this analysis due to small sample size. The federally eligible population includes all lawfully residing children in states that adopted CHIPRA (see Table 1 and Box 2 for definitions of federally eligible and ineligible children).
Source: These 2019 data result from MPI analysis of data from the 2015–19 ACS, pooled, and the 2008 SIPP, weighted to 2019 unauthorized immigrant population estimates provided by Van Hook.

B. State-by-State Participation Rates

Nationwide, 92 percent of all income-eligible U.S.-born children without private insurance were enrolled in Medicaid and CHIP in 2019 (see Table 3). Among federally eligible immigrant children, this share was 74 percent—18 percentage points lower than for U.S.-born children. This analysis also points to important variations by state:

- In 35 states and the District of Columbia, participation rates for U.S.-born income-eligible children were at or above 90 percent. The highest participation rates occurred in Massachusetts, Vermont, and the District of Columbia.
- The lowest participation rates for U.S.-born children were in Utah, North Dakota, and Wyoming, ranging from 79 percent to 81 percent.
- Participation rates of federally eligible immigrant children varied much more widely, from 36 percent in Utah to 94 percent in Massachusetts.
- In four states, the participation rates of federally eligible immigrant children were at or above 90 percent: Massachusetts, New York, Michigan, and Washington. While children in these states have access to federally funded Medicaid and CHIP, it is noteworthy that Massachusetts, New York, and Washington also provide state-funded coverage to all income-eligible children irrespective of immigration status.
- For federally eligible immigrant children, the state with the lowest participation rate was Utah (also true for U.S.-born children), followed by Arkansas, South Carolina, Texas, and Nevada.

TABLE 3

Medicaid and CHIP Participation Rates among Income-Eligible Children (ages 0–18), by Nativity and Federal Eligibility, 50 States and the District of Columbia, 2019

	U.S.-Born Children	Federally Eligible Immigrant Children
Alabama	95%	60%
Alaska	84%	-
Arizona	87%	72%
Arkansas*	93%	38%
California**	95%	86%
Colorado*	92%	65%
Connecticut*	95%	74%
Delaware*	95%	70%
District of Columbia**	97%	-
Florida*	90%	65%
Georgia	87%	53%
Hawaii*	95%	83%
Idaho	92%	72%
Illinois**	94%	84%
Indiana	86%	70%
Iowa*	94%	84%
Kansas	89%	66%
Kentucky*	94%	75%
Louisiana*	96%	54%
Maine*	90%	88%
Maryland*	94%	69%
Massachusetts**	98%	94%
Michigan	94%	91%
Minnesota*	93%	87%
Mississippi	93%	-
Missouri	87%	71%
Montana*	88%	-
Nebraska*	87%	69%
Nevada*	88%	48%
New Hampshire	93%	78%
New Jersey*	93%	71%
New Mexico*	94%	50%
New York**	95%	91%
North Carolina*	93%	56%
North Dakota	80%	-

TABLE 3 (cont.)

Medicaid and CHIP Participation Rates among Income-Eligible Children (ages 0–18), by Nativity and Federal Eligibility, 50 States and the District of Columbia, 2019

	U.S.-Born Children	Federally Eligible Immigrant Children
Ohio*	92%	76%
Oklahoma	89%	63%
Oregon**	93%	86%
Pennsylvania*	91%	77%
Rhode Island*	96%	84%
South Carolina*	93%	42%
South Dakota	87%	-
Tennessee	93%	56%
Texas*	86%	47%
Utah*	79%	36%
Vermont*	98%	-
Virginia*	90%	62%
Washington**	95%	90%
West Virginia*	96%	-
Wisconsin*	91%	76%
Wyoming	81%	-
U.S. Total	**92%**	**74%**

* States that have adopted the CHIPRA option.
** States that have adopted CHIPRA and also have state-funded programs that cover unauthorized immigrant children.
Notes: Categories marked "-" have a sample size too small to generate statistically meaningful results. Participation rates are computed by taking the ratio of children participating in Medicaid or CHIP to the income-eligible population who do not have another form of insurance. The federally eligible population includes all lawfully residing children in states that adopted CHIPRA (see Table 1 and Box 2 for definitions of federally eligible and ineligible children). Determination of FPL is based on the author's computation of family to poverty ratio to account for adjusted gross income and poverty guidelines set by HHS.
Source: These 2019 data result from MPI analysis of data from the 2015–19 ACS, pooled, and the 2008 SIPP, weighted to 2019 unauthorized immigrant population estimates provided by Van Hook.

On average, states that adopted the CHIPRA option to cover children who were recent LPRs or lawfully present non-LPRs generally had higher Medicaid and CHIP participation rates for federally eligible immigrant children than states that did not take this option. In 2019, the participation rate for federally eligible immigrant children was 74 percent in CHIPRA states versus 68 percent in non-CHIPRA states.

Yet electing the CHIPRA state option does not guarantee higher participation among federally eligible immigrant children: the five lowest ranked states mentioned above (Utah, Arkansas, South Carolina, Texas, and Nevada) had also all elected the CHIPRA option. Other barriers that depress immigrant participation in Medicaid and CHIP may exist in these states. This was particularly so in the period surrounding the Trump administration's public-charge rule, when confusion about the consequences of participating in public benefits and concerns that using health coverage would affect an immigrant's future immigration status led many immigrants to avoid public benefits.[16] For example, immigrant children in Utah saw drops in health insurance cov-

erage between 2016 and 2019, with much of the loss attributed to an increase in fear of immigration enforcement and other anti-immigration policies from the Trump administration.[17] Similar issues were associated with increased disenrollment from Medicaid and CHIP in Texas[18] and Nevada,[19] as was the lack of access to material and campaign outreach in Spanish, which represented an additional barrier to Latino immigrant children's participation. The Trump administration's public-charge rule was withdrawn by the Biden administration in March 2021 after a federal court vacated it, and a new proposed rule that broadly returns to the pre-Trump field guidance has been posted for comments.[20]

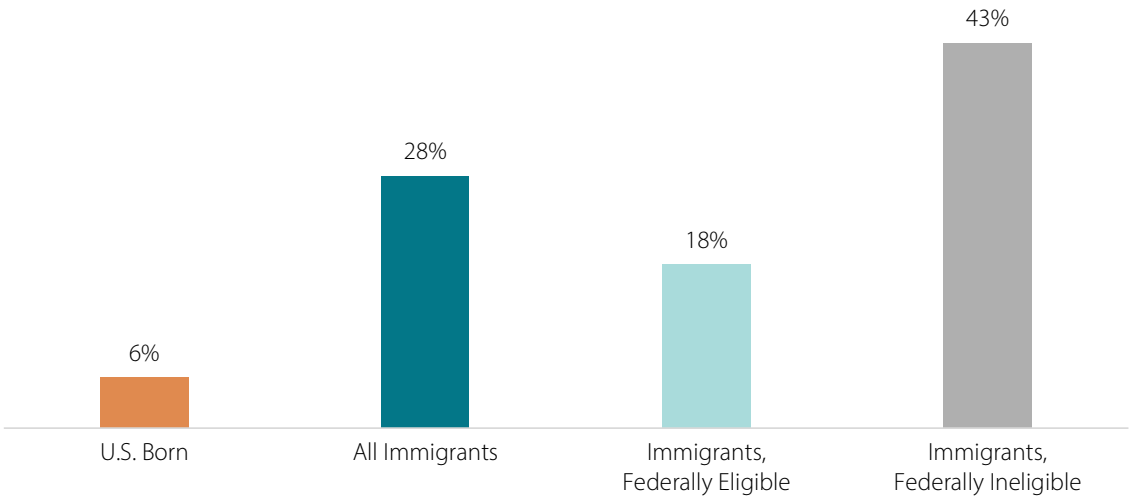
4 Uninsured Rates among Income-Eligible Children

The United States has one of the highest child poverty rates in the developed world.[21] Research shows that child poverty, often associated with lower rates of health insurance coverage, is strongly correlated with chronic illness and higher medical costs in adulthood.[22] Accounting for children who were income eligible for Medicaid and CHIP in their state, an estimated 3 million children ages 0 to 18 across the United States were uninsured in 2019. This includes 2.4 million uninsured income-eligible U.S.-born children, one-quarter of whom had at least one immigrant parent, and 646,000 income-eligible foreign-born children. (There are even more children in the United States who are uninsured, but their families' incomes exceed the limits for Medicaid and CHIP eligibility in their state of residence.)

Immigrant children lack insurance at notably higher rates than U.S.-born children. Nationwide, 6 percent of U.S.-born children with family incomes eligible for Medicaid and CHIP did not have any health insurance coverage—public or private—in 2019 (see Figure 5). The uninsured rate among all income-eligible foreign-born children was 28 percent. This high uninsured rate hides the differentiated access that

FIGURE 5

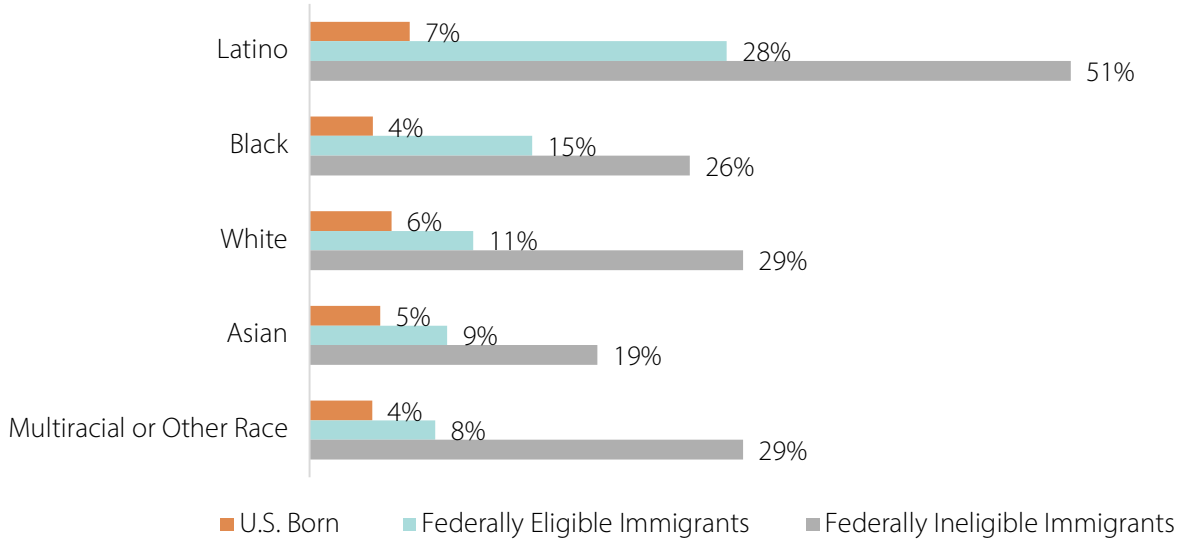
Uninsured Rates of Children (ages 0–18) Who Are Income Eligible for Medicaid and CHIP, by Nativity and Federal Eligibility, United States, 2019



Notes: Uninsured children are without public or private health insurance. The federally eligible population includes all lawfully residing children in states that adopted CHIPRA (See Table 1 and Box 2 for definitions of federally eligible and ineligible children).
Source: These 2019 data result from MPI analysis of data from the 2015–19 ACS, pooled, and the 2008 SIPP, weighted to 2019 unauthorized immigrant population estimates provided by Van Hook.

FIGURE 6

Uninsured Rates among Children (ages 0–18) Who Are Income Eligible for Medicaid and CHIP, by Nativity and Race and Ethnicity, United States, 2019



Notes: In this figure, all racial/ethnic categories are mutually exclusive, and all Latinos are included in that category regardless of their race. "Multiracial or other race" includes respondents who self-identified with more than one race or selected another race not listed in the ACS. Native Americans are excluded from this analysis due to small sample size. The federally eligible population includes all lawfully residing children in states that adopted CHIPRA (see Table 1 and Box 2 for definitions of federally eligible and ineligible children).
Source: These 2019 data result from MPI analysis of data from the 2015–19 ACS, pooled, and the 2008 SIPP, weighted to 2019 unauthorized immigrant population estimates provided by Van Hook.

federally eligible and ineligible immigrant children had to Medicaid and CHIP: 18 percent of federally eligible children were uninsured, compared to 43 percent of federally ineligible children. Still, it is noteworthy that immigrant children who met both income and immigration-status requirements for Medicaid and CHIP had an uninsured rate that was three times higher than that of U.S.-born children in the same income category.

Immigrant children who met both income and immigration-status requirements for Medicaid and CHIP had an uninsured rate that was three times higher than that of U.S.-born children in the same income category.

Federally ineligible immigrant children of all races and ethnicities faced high uninsured rates: in 2019, the shares of federally ineligible children who were uninsured varied from 19 percent among Asians to 51 percent among Latinos (see Figure 6). For federally eligible immigrant children, the likelihood of being uninsured was also the highest among Latino children, at 28 percent. The uninsured rate for federally eligible immigrants was also high among Black children (15 percent), especially when compared to U.S.-born Black children who had one of the lowest uninsured rates (4 percent) of all U.S.-born racial and ethnic groups in this income category. The shares of federally eligible immigrant children who were uninsured were lower among Asian, White, and multiracial immigrant children, though all were greater than the rates for U.S.-born children in their respective racial/ethnic category.

5 Conclusion

Overall, very high participation in public health benefits among U.S. children shows the effectiveness of Medicaid and CHIP in reaching low-income children and reducing their uninsured rates. This stands in stark contrast to Medicaid participation among adults, which is quite low.[23] This difference may partly be a function of the fact that Medicaid and CHIP combined coverage is much more generous for children than for adults, particularly considering dozens of states did not take the ACA-authorized expansion of Medicaid for adults.

Yet the picture for immigrant children is more mixed than for their U.S.-born peers. Three findings stand out from this analysis:

- **Federal restrictions prevented about 909,000 income-eligible immigrant children from participating in Medicaid and CHIP in 2019.** This includes not only unauthorized immigrant children who were precluded from public benefits even before PRWORA, but also green-card holders with fewer than five years in that status and certain other lawfully present immigrants.
- **Federally eligible immigrant children—those who meet both income and immigration requirements—participate substantially less in Medicaid and CHIP than U.S.-born children.** In 2019, this was especially the case in states that have not taken the CHIPRA option. States with low participation among federally eligible immigrant children, and those that have yet to expand health-care access to lawfully present immigrant children via the CHIPRA option forgo the matching funds the federal government provides states for all participants in these programs.[24] These transfers of federal matching funds can have positive effects on local economies in receiving states.[25]
- **For all racial and ethnic groups, immigrant children are more likely to be uninsured than their U.S.-born counterparts in families with similarly low incomes.** As might be expected, the uninsured share is very high for federally ineligible immigrant children of all racial and ethnic groups, but even for federally eligible immigrant children, uninsured rates are higher than among U.S.-born children—especially for Latino and Black children. The participation gaps between U.S.-born and federally eligible immigrant children may be a function of confusion around complex eligibility rules, access barriers such as language and comfort with federal agencies and health-care providers, or fear that participating in public benefits will have immigration consequences.

The nationwide picture of immigrant children's participation in Medicaid and CHIP does not tell the full story: important local dynamics may be at play in specific contexts. For example, in Texas, which had one of the lowest participation rates for federally eligible immigrant children, a Houston-based organization working directly with the city's immigrant communities has reported that the number of children enrolled in Medicaid and CHIP fell by 42 percent between 2016 and 2019, a period that coincided with the announcements and ultimate publication of the public-charge rule by the Trump administration.[26] While the public-charge rule has since been withdrawn by the Biden administration, evidence on its chilling effects suggest that large-scale outreach efforts in immigrant communities, ideally in the target community's language, are necessary to counter misinformation and confusion about the consequences of using public benefits for which low-income immigrant children are eligible.

Both national and state participation trends have likely evolved further since the data analyzed in this brief were collected, which occurred before the Biden administration took office, removed the prior administration's public-charge rule, and supported outreach and extended ACA enrollment. The need for health coverage has also increased during the pandemic, likely prompting some immigrant families to enroll their eligible children in Medicaid and CHIP. Notwithstanding any improvements in participation, federal eligibility rules continue to exclude hundreds of thousands of immigrant children from these key safety-net programs and may deter many others from participating. Lack of health coverage for this large group of children may compromise their health and development, leading to costly medical conditions and lower productivity later in life.

Lack of health coverage for this large group of children may compromise their health and development.

Endnotes

1 Mariellen Jewers and Leighton Ku, "Noncitizen Children Face Higher Health Harms Compared with Their Siblings Who Have US Citizen Status," *Health Affairs Journal* 40, no. 7 (2021): 1084–1089.

2 See the *Balanced Budget Act of 1997* statute creating the Children's Health Insurance Program: *Balanced Budget Act of 1997*, Public Law 105-33, *U.S. Statutes at Large* 111 (August 5, 1997): 251, Title IV. See also the *Patient Protection and Affordable Care Act* (ACA) statute expanding CHIP: *Patient Protection and Affordable Care Act*, Public Law 111-148, *U.S. Statutes at Large* 124 (March 23, 2010): 119, Sec. 10203.

3 Medicaid is a public insurance program for low-income families and individuals that is jointly financed by the federal government and states. See Social Security Administration, "Grants to States for Medical Assistance Programs," 42 *U.S. Code* 1396. The federal government requires states to cover certain mandatory populations and services, but states can choose to extend eligibility and coverage within the federal statute's basic framework and pursuant to authorized waivers. See Social Security Administration, "General Provisions, Peer Review, and Administrative Simplification—Demonstration Projects," 42 *U.S. Code* 1315, Section 115; Social Security Administration, "Grants to States for Medical Assistance Programs—Provisions Respecting Inapplicability and Waiver of Certain Requirements of this Title," 42 *U.S. Code* 1396n, Sections 1915(b) and 1915(c).

4 States use three different models to administer Medicaid and CHIP: (1) they provide CHIP as a separate program from Medicaid, (2) they expand the Medicaid program, or (3) they implement a combined approach. In states with a separate CHIP program, children are enrolled in CHIP. In states with expanded Medicaid, they are enrolled in Medicaid using federal CHIP funds. Some states, such as Alabama, use CHIP funds to expand Medicaid coverage to certain children while also operating a separate CHIP program for other low-income children. For the purposes of this brief, all children under age 19 enrolled in any of these state models are treated as Medicaid and CHIP participants.

5 See the *Personal Responsibility and Work Opportunity Reconciliation Act* (PRWORA) statute outlining eligibility for noncitizens: *Personal Responsibility and Work Opportunity Reconciliation Act of 1996*, Public Law 104-193, *U.S. Statutes at Large* 110 (August 22, 1996): 2105, Sec. 401–403.

6 Valerie Lacarte, Mark Greenberg, and Randy Capps, *Medicaid Access and Participation: A Data Profile of Eligible and Ineligible Immigrant Adults* (Washington, DC: Migration Policy Institute, 2021).

7 Lacarte, Greenberg, and Capps, *Medicaid Access and Participation*.

8 National Conference of State Legislatures, "Children's Health Insurance Program Overview," updated September 4, 2020.

9 As of June 2022, 34 states and the District of Columbia offered coverage to lawfully residing children through the CHIPRA option. See Center for Medicaid and CHIP Services (CMCS), "Medicaid and CHIP Coverage of Lawfully Residing Children & Pregnant Women," updated July 9, 2021.

10 CMCS, "Medicaid and CHIP Coverage."

11 In addition to the District of Columbia and six states that currently cover all income-eligible unauthorized immigrant children (California, Illinois, Massachusetts, New York, Oregon, and Washington), four other states plan to extend coverage by 2023. Maine and Vermont will cover all children regardless of status by July 1, 2022. Children in New Jersey will be eligible for a "buy-in" program or another form of coverage by July 2022. And by January 2023, Connecticut will cover all children under age 9 regardless of immigration status. Coverage for income-eligible adults, regardless of immigration status, will also be expanded in 2022 in Illinois (adults ages 55 to 64 by May 2022) and Oregon (all adults by July 2022). See National Immigration Law Center, "Table 3: Medical Assistance Programs for Immigrants in Various States," updated July 2021.

12 Julia Gelatt, *Immigrant Workers: Vital to the U.S. COVID-19 Response, Disproportionately Vulnerable* (Washington, DC: Migration Policy Institute, 2020).

13 Multiracial immigrant children represented 3 percent. Native Americans were excluded from this analysis due to small sample size. These 2019 data result from Migration Policy Institute (MPI) analysis of data from the 2015–19 American Community Survey (ACS), pooled, and the 2008 Survey of Income and Program Participation (SIPP), weighted to 2019 unauthorized immigrant population estimates provided by Jennifer Van Hook at The Pennsylvania State University.

14 MPI Migration Data Hub, "Unauthorized Immigrant Population Profiles," accessed March 2, 2022.

15 MPI Migration Data Hub, "Unauthorized Immigrant Population Profiles."

16 Randy Capps, Michael Fix, and Jeanne Batalova, "Anticipated 'Chilling Effects' of the Public-Charge Rule Are Real: Census Data Reflect Steep Decline in Benefits Use by Immigrant Families" (commentary, MPI, Washington, DC, December 2020); Hamutal Bernstein, Dulce Gonzalez, Michael Karpman, and Stephen Zuckerman, "Amid Confusion over the Public Charge Rule, Immigrant Families Continued Avoiding Public Benefits in 2019" (issue brief, Urban Institute, Washington, DC, May 2020).

17 Voices for Utah Children, "10,000 More Utah Kids," updated September 30, 2020; Voices for Utah Children, "Coverage for All Utah Kids: A Look at the Benefits and Estimated Costs," updated January 26, 2021.

18 Clara Alvarez Caraveo, Luis E. Basurto, Dulce Gonzalez, and Clare Pan, "Barriers to Medicaid and CHIP Coverage for Eligible but Uninsured Latinx Children: A Texas Case Study" (issue brief, Urban Institute, Washington, DC, February 2021).

19 Guinn Center, "Nevada's Uninsured Population" (issue brief, Guinn Center, Las Vegas, 2019).

20 U.S. Citizenship and Immigration Services (USCIS), "Inadmissibility on Public Charge Grounds; Implementation of Vacatur," *Federal Register* 86, no. 48 (March 15, 2021): 14221. For the Biden administration's proposed rule, see USCIS, "Public Charge Ground of Inadmissibility," *Federal Register* 87, no. 37 (February 24, 2022): 10570.

21 Melissa Kearney, "Child Poverty in the U.S.," EconoFact, February 5, 2021.

22 Center for Poverty Research, "Poverty Research Now: Focus on Poverty and Health" (research newsletter, UC Davis Center for Poverty Research, Davis, CA, June 2014). For information on the relationship between poverty and uninsured rates, see Center for Poverty Research, "How Does Poverty Relate to Health Insurance Coverage?," accessed March 2, 2022.

23 Lacarte, Greenberg, and Capps, *Medicaid Access and Participation*.

24 Robin Rudowitz, Samantha Artiga, and Rachel Arguello, "Children's Health Coverage: Medicaid, CHIP and the ACA" (issue brief, Kaiser Family Foundation, Washington, DC, March 26, 2014).

25 Kaiser Family Foundation, "Medicaid Financing: An Overview of the Federal Medicaid Matching Rate (FMAP)" (issue brief, Kaiser Family Foundation, San Francisco, September 2012).

26 A Houston-based organization working primarily with low-income immigrant families reported these numbers. See Cheasty Anderson, *Public Charge and Private Dilemmas: Key Challenges and Best Practices for Fighting the Chilling Effect in Texas, 2017-2019* (Austin, TX: Children's Defense Fund – Texas, 2020).

About the Author

VALERIE LACARTE

Valerie Lacarte is a Senior Policy Analyst at the Migration Policy Institute (MPI) Human Services Initiative, where she contributes to research design and methodology, and conducts data analysis on a range of issues including access to public benefits.

Prior to joining MPI, Dr. Lacarte was a postdoctoral fellow at the Institute for Women's Policy Research, a think tank dedicated to the empirical analysis of women's economic security. Previously, she worked at the Organization of American States and the Inter-American Development Bank, where she gained expertise on regional integration and international trade, with a focus on Latin America and the Caribbean.

Dr. Lacarte earned a PhD in economics from American University. For her dissertation, she used a mixed-methods approach to study the integration of Caribbean immigrants into the U.S. labor market, and the intersectionality of race, ethnicity, and cultural gender norms.

Acknowledgments

The author thanks the David and Lucile Packard Foundation, the Annie E. Casey Foundation, and the W.K. Kellogg Foundation for their support of this research. This brief is the second in a series of publications by the Migration Policy Institute (MPI) Human Services Initiative to study immigrants' access to and participation in federal means-tested public benefits in the United States.

The author thanks her former colleagues Mark Greenberg and Randy Capps, who during their time at MPI contributed substantially to the design of this brief. The author also thanks MPI colleagues Essey Workie and Michael Fix for their valuable comments; Julia Gelatt, for her detailed review of the methodology and analysis; Lillie Hinkle, for their contributions to the literature review; and former MPI interns Anna deDufour, Shiyue Cui, and Briana Broberg for their reliable and timely research support. In addition, the author thanks MPI colleagues Lauren Shaw and Michelle Mittelstadt for their close edits to the final draft and thoughtful outreach.

Special thanks also go to Tanya Broder, Senior Staff Attorney at the National Immigration Law Center (NILC); Gabrielle Lessard, Senior Policy Attorney at NILC; and Jennifer Tolbert, Director of State Health Reforms at the Kaiser Family Foundation for their useful comments on an earlier draft of this brief.

MPI is an independent, nonpartisan policy research organization that adheres to the highest standard of rigor and integrity in its work. All analysis, recommendations, and policy ideas advanced by MPI are solely determined by its researchers.

Design: Sara Staedicke, MPI
Layout: Liz Hall

Suggested citation: Lacarte, Valerie. 2022. *Immigrant Children's Medicaid and CHIP Access and Participation: A Data Profile*. Washington, DC: Migration Policy Institute.

www.migrationpolicy.org

The Migration Policy Institute is an independent, nonpartisan think tank that seeks to improve immigration and integration policies through authoritative research and analysis, opportunities for learning and dialogue, and the development of new ideas to address complex policy questions.

1275 K St NW, Suite 800, Washington, DC 20005
202-266-1940