Introduction

For over a decade, Michigan has had the ability to be more inclusive and enroll thousands more of the state’s children in Medicaid and the Children’s Health Insurance Program (CHIP) but has not yet opted to do so. Specifically, these children are “lawfully residing,” or lawfully present immigrants who meet Medicaid or CHIP state residency and income requirements, yet have lived in the United States for fewer than five years. Federal law requires lawfully residing immigrants to live in the country for five years before they can enroll in some public programs. The 2009 Children’s Health Insurance Program Reauthorization Act (CHIPRA), however, gave states the Immigrant Children’s Health Improvement Act (ICHIA) option to waive the five-year waiting period for Medicaid and CHIP for lawfully residing children (up to 21 years old) and/or pregnant people.¹

If Michigan were to take up the ICHIA option for children, the state would be able to enroll thousands of eligible lawfully residing children in these healthcare programs and receive substantial federal matching funds to do so. This administrative policy change would expand access to comprehensive healthcare coverage for Michigan’s immigrant children—particularly Hispanic or Latinx children. By taking up the ICHIA option for pregnant people, Michigan could secure future coverage gains for those enrolled in the state’s Maternity Outpatient Medical Services (MOMS) program, which currently provides prenatal care and up to 60 days of postpartum care to Medicaid-eligible pregnant people, regardless of immigration status.

Given MOMS’ reach and funding structure, this report focuses primarily on using the ICHIA option to extend Medicaid and CHIP to immigrant children sooner, and the impact this policy change would have. Michigan should make use of all its available policy options—particularly those that include built-in federal funding—as we strive to attain healthcare coverage for all kids and achieve healthier outcomes in our state.
Background

There are two main categories of foreign-born, lawfully present people in the United States: immigrants, who are admitted into the country for permanent residence and nonimmigrants, who are admitted into the country temporarily for study or work, for example.  

(Refugees and asylees, once admitted, may apply to adjust their status to become permanent residents.) The sweeping 1996 welfare reform law, or the Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA), placed many federal restrictions on immigrants’ access to public benefits. The law divided lawfully present immigrants into two narrower groups: "qualified" and "non-qualified," where the former comprises the group of noncitizens who are potentially eligible for public benefits. PRWORA imposes further restrictions, including a five-year waiting period (or "bar") for Medicaid and CHIP, which prevent certain qualified immigrants who entered the United States on or after August 22, 1996 from enrolling in full-scope Medicaid until they have lived in the country for five years. In contrast to full-scope coverage, “emergency Medicaid” (also known in Michigan as Emergency Services Only coverage) will cover only emergency care and services, and it is available to anyone who is eligible for Medicaid—save for their immigration status—without a five-year wait.

The federal five-year waiting period includes most lawfully residing children and pregnant people who are otherwise eligible for Medicaid or CHIP based on income but not immigration status. Prior to 1996, there were generally few differences between most lawful permanent residents (LPRs, or “green card” holders), other noncitizens and United States citizens in regards to eligibility for major public programs. Despite some changes in law over subsequent decades, PRWORA intricately linked federal immigration policy and public benefits and legitimized immigrant exclusion in policies to come, which has impacted the accessibility and reach of such programs for millions of immigrant families from 1996 to today.

There are, however, groups of qualified immigrants who are exempt from the federal five-year waiting period, such as refugees and asylees, those serving in the Armed Forces and certain survivors of severe forms of trafficking. Therefore, those who are subject to the five-year waiting period include: LPRs who arrived on or after August 22, 1996; individuals paroled into the U.S. for a period of at least one year; and certain survivors of battery or extreme cruelty and their family members. When states take up the ICHIA option, they allow Medicaid- and CHIP-eligible children and pregnant people who are lawfully present (including LPRs and others) and have lived in the country for less than five years to become eligible for Medicaid and CHIP without a five-year wait. Furthermore, these states are able to draw down federal matching dollars to cover a large portion of the cost of extending coverage to these additional residents.

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From the state policy perspective, making use of the ICHIA option to expand healthcare coverage among immigrant children and pregnant people would align Michigan law with that of most states. In fact, Michigan is one of only 16 states that still does not allow eligible lawfully residing children to obtain Medicaid and CHIP coverage without a five-year wait (and it is one of 26 states that does not allow pregnant people to do so). In the Great Lakes region, six out of eight states have made use of the ICHIA option for children, except for Michigan and Indiana, where thousands of lawfully residing immigrant children continue to be excluded from health programs, despite otherwise being eligible for Medicaid or CHIP. Most of Michigan's peers, not only among Great Lakes states but also across the country, have agreed that taking up the ICHIA option is an important opportunity to move closer to covering all children.

35 other states have adopted the ICHIA option to extend Medicaid and CHIP coverage to lawfully residing immigrant children without a five-year wait.

The ICHIA option would extend health insurance coverage to 3,000 to 4,000 children. Through the ICHIA option included in CHIPRA, lawfully residing children (up to 21 years old) and pregnant people in Michigan could be eligible for Medicaid or CHIP coverage without a five-year wait. Newly eligible groups would include children or pregnant people who are lawfully present (including LPRs, nonimmigrants and those with Temporary Protected Status, for example) and currently meet Medicaid or CHIP income requirements. Based on these criteria, approximately 3,000 to 4,000 Michigan children would become eligible for healthcare coverage through Medicaid and CHIP via the ICHIA option. Some of these children may be enrolled in other coverage, such as Marketplace coverage through the Affordable Care Act (ACA), since lawfully present immigrants are eligible for such coverage and associated subsidies. Yet, Medicaid and CHIP offer comprehensive coverage with lower premiums and controlled out-of-pocket spending, which would make coverage more affordable for these children's families. Furthermore, immigrant Michiganders are twice as likely to be uninsured than residents who are U.S.-born, with over two-thirds of immigrants who are uninsured being noncitizens. The ICHIA option's targeted scope would result in a small increase in the number of children who are insured, but it would also reduce the uninsured rate among noncitizen residents specifically. This policy change would bring Michigan closer to covering all children—and providing affordable, quality care to thousands more children in our state—while aligning our state law with that of most other states.

The ICHIA option could cement access to future coverage gains for pregnant immigrants in Michigan. Michigan currently provides prenatal care and up to 60 days of postpartum care to Medicaid-eligible pregnant people, regardless of immigration status, through its Maternity Outpatient Medical Services (MOMS) program. In 2016, more than 5,000 pregnant people in Michigan received coverage through this option via MOMS. This state-funded program leverages CHIP’s “unborn child option,” which allows states to provide coverage to the fetus and effectively cover pregnant parents-to-be who would otherwise be ineligible for full-scope Medicaid coverage due to immigration status. (In addition, Emergency Services Only Medicaid covers labor and delivery services for those enrolled in MOMS.) Although the state already receives federal matching dollars to cover pregnant immigrants, expanding Medicaid and CHIP eligibility criteria to include pregnant immigrants via the ICHIA option could cover new parents directly and secure access to future coverage gains. For example, future extensions to postpartum coverage for people enrolled in Medicaid (from 60 days to a full year, for example) through administrative policy changes would benefit these pregnant people themselves (as opposed to their unborn children), for whom such coverage extension may not otherwise be guaranteed under current policy. Therefore, the ICHIA option can be an immigrant-inclusive opportunity to build on the MOMS program and proactively ensure future coverage gains for pregnant immigrants in our state.

The ICHIA option would extend coverage to more Hispanic or Latinx children, who are more likely to be uninsured in Michigan. Children in immigrant families who are themselves foreign-born parent come from all over the world. Per American Community Survey (ACS) data, in Michigan, the majority were born in Asia or Latin America (50% and 26%, respectively), with others born in Europe.
Of course, this regional data encompasses immigrants of varying races and ethnicities who were born in these areas of the world (e.g., not all European immigrants are White). There is broad diversity within these groups, and in addition to questions about country of origin, the ACS asks about race and ethnicity as two separate questions. There are specific data concerns and collection challenges regarding the ACS’ separation of race and ethnic identity, such as with the definition of “Hispanic/Latino,” which can lead to under-sampling and other inaccuracies. Noting these considerations, children in Michigan’s immigrant families are most likely to be Asian or Hispanic or Latinx, or have parents who identify as such.

A history of racial and economic geographic segregation, in addition to institutional racism in areas like housing and employment, continue to impact families of color in Michigan—particularly Black or African American, Hispanic or Latinx, and Indigenous or American Indian families—by limiting both the access to, and equitable distribution of, resources like healthcare, healthy food, education and employment. In addition to institutional barriers, for some immigrant parents, challenges around language access and barriers to licensing or jobs in one’s field of expertise may also contribute to difficulty accessing higher-paying jobs. These barriers contribute to Black or African American children, Hispanic or Latinx children, and children of two or more races in Michigan being more likely to live in families that are considered poor or low income (with incomes less than 200% of the federal poverty threshold). These data also show that on the whole, Asian and Pacific Islanders are less likely to live in families that are considered poor or low-income, but it is also true that among the diverse Asian and Pacific Islander population there are wide variations in income by country of origin, which are not distinguishable here.

Compared with other racial and ethnic groups, Hispanic or Latinx children in Michigan are less likely to have health insurance, with 7% being uninsured. Notably, this rate is double that of all other racial and ethnic groups and has increased over the last few years. If the state were to take up the ICHIA option, it would impact uninsured children who are immigrants and also live in families that are considered poor or low income. In Michigan, coverage via the ICHIA option would extend to Hispanic or Latinx children in particular because they represent a large share of those who are themselves foreign-born or are a part of immigrant families, are more likely to be income-eligible for Medicaid and CHIP and are more likely to be uninsured than children in other racial groups today.
Hispanic or Latinx children in Michigan are more likely to live in families considered poor or low income, uninsured at double the rate of children of other races.

<table>
<thead>
<tr>
<th>Race</th>
<th>Children below 200% of poverty*</th>
<th>Children without health insurance</th>
</tr>
</thead>
<tbody>
<tr>
<td>American Indian</td>
<td>S</td>
<td>S</td>
</tr>
<tr>
<td>Asian and Pacific Islander</td>
<td>17,000</td>
<td>2,000</td>
</tr>
<tr>
<td>Black or African American</td>
<td>211,000</td>
<td>11,000</td>
</tr>
<tr>
<td>Hispanic or Latino</td>
<td>102,000</td>
<td>13,000</td>
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<tr>
<td>Non-Hispanic White</td>
<td>435,000</td>
<td>48,000</td>
</tr>
<tr>
<td>Two or more races</td>
<td>65,000</td>
<td>40,000</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>822,000</td>
<td>78,000</td>
</tr>
</tbody>
</table>

S: Estimates suppressed when the confidence interval around the percentage is greater than or equal to 10 percentage points.

“Non-Hispanic White” is the only exclusively non-Hispanic category, all others include anyone who identifies as the listed racial group. “Two or more races” includes those who self-identified as two different racial groups, regardless of Hispanic or Latino identity.

* The federal poverty definition consists of a series of thresholds based on family size and composition. In 2019, a 200% poverty threshold for a family of two adults and two children was $51,853. The Annie E. Casey Foundation, KIDS COUNT Data Center, 2019 American Community Survey estimates through the U.S. Census Bureau.

The ICHIA option would contribute to a climate of inclusion and could promote re-enrollment after the “public charge”-induced chilling effect. The rate of Michigan children without health insurance increased for two groups from 2017 to 2019: Hispanic or Latinx children (4% to 7%) and children of two or more races (2% to 3%). National context provides insight into these increases. For example, massive cuts to navigator funding (over 80% in two years by 2018) meant that programs that support consumers’ enrollment in ACA Marketplace plans, often by providing objective information and help with eligibility, were forced to limit their activity. Explicitly anti-immigration policies such as a 2019 presidential proclamation requiring proof of health insurance (or means to obtain it quickly) to lawfully immigrate to the country also limited immigration options for many lower-income people, contributed to a narrative about immigrants burdening the healthcare system and created a climate of fear about enrollment, which deterred families from enrolling in robust coverage. Finally, changes that the Trump administration made to longstanding “public charge” rules that made it harder for noncitizens to obtain future permanent residency (such as a “green card”) if they used public benefits, including Medicaid. Although in Michigan nearly nine in 10 children in immigrant families are citizens, 28% of all children in immigrant families live in “mixed immigration status” households, where at least one parent is a noncitizen. Messaging and misinformation about the new public charge rule led many families with eligible children (citizen children, e.g.) to disenroll because of...
fears and confusion about the impact on parents who might be hoping to adjust their immigration status in the future. In fact, survey data found that nationally, one in five adults in immigrant families with children reported that they or a family member avoided a public benefit in 2019 for fear of risking future green card status. For those with lower incomes, this number increases to close to one-third of respondents (31.5%).

As noted earlier, over a quarter of Michigan children in immigrant families are themselves from Latin America or have parents from this region, and Hispanic or Latinx children in the state are disproportionately more likely to be eligible for public programs based on income. Concerns about changes to the public charge rule likely help explain the increase in the uninsured rate for Hispanic or Latinx children, with fears about the rule and its impact resulting in a “chilling effect” on enrollment in public programs of all types, including Medicaid and CHIP, due to eligible families disenrolling their children from such programs.

In March 2021, the Biden administration formally rescinded the Trump-era public charge rule after the Department of Justice stopped defending the rule through legal avenues. With the rule now rescinded, there should be a push in our state to re-enroll eligible children, particularly Hispanic or Latinx children, as Michigan continues to climb toward covering all kids. The ICHIA option is an existing tool the state can use to reach this goal and will create a more welcoming Michigan by enacting explicitly immigrant-inclusive policy that affirms coverage options for immigrants. These actions could combat a climate of fear and instead send a powerful message to parents and families that public programs like Medicaid and CHIP are available to a broader group of eligible immigrant residents and their children; that families should not be deterred from enrolling in public programs; and that Michigan is using all of its available options to provide comprehensive coverage to immigrant families, which for the last decade has included the opportunity of expansion via the ICHIA option.

**Impact on Healthcare Access, Coverage and Affordability**

Healthcare coverage through Medicaid and CHIP can lead to consistent care for children and support financial stability for families. These programs help children and families meet myriad health needs: those who enroll in Medicaid or CHIP in Michigan receive a comprehensive package of healthcare benefits including vision, dental and mental health services. The cost of care is also affordable, as enrolling in CHIP through MIChild in Michigan costs $10 per family (including all children in the family) and CHIP programs must limit out-of-pocket spending (including premiums) to 5% of family income.

For families enrolled in these programs, low premiums and controlled out-of-pocket spending can provide financial security against unexpected medical bills. In fact, research has shown that expanded Medicaid coverage is associated with improved housing stability and fewer evictions, since medical debt or other urgent health needs can compete with families’ other financial obligations, like housing costs. In addition, research on the impact of Medicaid and CHIP coverage for children demonstrates better access to primary and preventive care and fewer unmet health needs when
compared with uninsured children. A study examining the impact of extending Medicaid and CHIP coverage to lawfully residing children showed that states that had made such a policy change as of 2011 saw a nearly 14% decrease in the probability of immigrant children experiencing any unmet need, while also improving access to consistent preventive care.

Impact on State Budget

There are clear health benefits to extending affordable coverage to more children. Plus, if Michigan were to expand coverage through the ICHIA option for children and pregnant people, the cost to the state would be limited. Medicaid postpartum coverage extensions for pregnant immigrants, for example, would be matched at the Medicaid Federal Medical Assistance Percentage (FMAP) rate. For newly enrolled immigrant children, Michigan would receive matching payments at the Enhanced FMAP rate for CHIP (80.18% for Michigan), meaning the state would be responsible for less than one-fifth of the total cost per child during their first five years in the country. Currently, over 1 million children (up to 21 years old) are enrolled in Medicaid programs in Michigan. The increase in eligible children due to expansion via the ICHIA option would be less than one-half of a percent of total enrolled children, and the state would take on a fraction of the cost of coverage.

It is time that Michigan made use of this long-standing policy option as we continue to make progress toward covering all children who call the Great Lakes State home, which includes immigrant children. In addition, by making use of the ICHIA option for pregnant people, Michigan could secure future coverage gains, beyond the current scope of the MOMS program, via Medicaid postpartum coverage extensions. Taking up the ICHIA option for immigrant children, in particular, will align Michigan law with that of much of the region and a majority of states across the country. Expanded eligibility for Medicaid and CHIP via the ICHIA option will provide access to comprehensive and affordable healthcare, especially to Hispanic and Latinx children. Although the number of children who will gain access to coverage is relatively small, the ICHIA option will have an impact on a group that is disproportionately more likely to be uninsured and will have a significant impact on the lives of lower-income immigrant children and their families by providing access to healthcare much sooner than is currently allowed by law. Given the rate of Hispanic and Latinx children who are uninsured in Michigan—likely exacerbated by fear surrounding the public charge rule changes and the resultant “chilling effect” on Medicaid and CHIP—the ICHIA option is one policy solution that will demonstrate a commitment to immigrant-inclusive policy and can help shrink this statistic. Plus, expanded eligibility comes with a lower price tag thanks to federal matching dollars to support care for this population, making the ICHIA option well worth the investment in creating a healthier future for more of Michigan’s children.

The League gratefully acknowledges the Georgetown University Center for Children and Families for their technical assistance and review of this report.

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End Notes


Currently, "qualified" immigrants include an individual who: is a legal permanent resident (LPR, also known as a green card holder); is granted asylum; is admitted to the U.S. as a refugee; is paroled into the U.S. for a period of at least one year; has been granted withholding of deportation; has been granted conditional entry; is a Cuban or Haitian entrant; is lawfully residing in the United States in accordance with a Compact of Free Association (individuals from the Republic of the Marshall Islands, the Federated States of Micronesia, and the Republic of Palau); or was born in Canada and is at least 50 percent American Indian, or is a member of a tribe recognized by the federal government. The statute also treats as qualified immigrants certain: (1) survivors of battery or extreme cruelty, as well as some of their family members; and (2) victims of severe forms of trafficking, as well as some of their family members.

5 Ibid. § 1613.

6 Ibid. §§ 1611(b)(1)(A).

7 Siskin, Alison, ibid.


9 8 U.S.C. §§ 1613(b), (d)(1). The following explanation of groups exempt from the five-year waiting period is provided in Grusin, Sarah and Catherine McKee, ibid.

Currently, the five-year waiting period does not apply to an individual who: is granted asylum; is admitted to the U.S. as a refugee; has been granted withholding of deportation; is a Cuban or Haitian entrant; is admitted to the U.S. as an Amerasian immigrant; is lawfully residing in any state and is: (1) an honorably discharged veteran; (2) on active duty in the armed forces; or (3) the spouse (including a surviving spouse who has not remarried) or unmarried dependent child of an honorably discharged veteran or individual on active duty; is lawfully residing in the United States in accordance with a Compact of Free Association; was born in Canada and is at least 50 percent American Indian, or is a member of a tribe recognized by the federal government; is granted Iraqi or Afghan special immigrant status; or is a child receiving foster care or adoption assistance under Title IV-E of the Social Security Act. In addition to the groups noted above, certain survivors of severe forms of trafficking and their family members are exempt from the five-year bar.

10 Grusin, Sarah and Catherine McKee, ibid.


12 The eight Great Lakes states include Illinois, Indiana, Michigan, Minnesota, New York, Ohio, Pennsylvania and Wisconsin.


14 Michigan Department of Attorney General. "AG Nessel Joins Coalition in Supreme Court Briefing Supporting the Rights of Temporary Protected Status Holders." News release, March 5, 2021. Retrieved from https://www.michigan.gov/ag/0,4534,7-359--553698--,00.html. There are more than 1,500 Temporary Protected Status holders in Michigan, some of whom are children that would be impacted by the ICHIA option.


25 Ibid.


28 Whitener, Kelly and Alexandra Corcoran, ibid.


33 Paradise, Julia, ibid.

