UNIVERSITAT DE BARCELONA

ISGlobal Barcelona Institute for Global Health

Legal Access of Migrants to U.S. Health and Social Welfare Policies in Response to COVID-19

Sarah Williams

Master of Global Health 2019-2020

Supervisor: Joan Tallada, Senior Advisor, Training and Education, ISGlobal

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Table of Contents

Abbreviations ..... *III*

Executive Summary *1*

1 Introduction *2*

1.1 Migration in the U.S. **2**

1.2 Migration and COVID-19 ..... **2**

1.3 Problem Statement/Justification **4**

1.4 Research Objectives **5**

2 Terms & Definitions *5*

3 Methodology *6*

3.1 Federal Analysis **6**

3.1.1 Search Strategy 6

3.1.2 Inclusion and Exclusion Criteria 7

3.1.3 Assessing Migrant Access to Benefits 8

3.2 State Analysis **9**

3.2.1 Search Strategy 9

3.2.2 Inclusion and Exclusion Criteria 9

3.2.3 Assessing Migrants Access to Benefits 10

3.3 Assessing Inconsistency of Policies **10**

4 Results *11*

4.1 Federal Means-Tested Benefits **12**

4.1.1 Migrant Qualification 14

4.1.2 Overview of Migrant Eligibility for Means-Tested Benefits from State-to-State 15

4.1.3 State Variances 19

4.1.4 Inconsistency 20

4.2 COVID-19 Benefits **23**

4.2.1 Coronavirus Legislation in Response to COVID-19 23

4.2.2 Overview of Migrant Access to COVID-19 Benefits 25

4.2.3 Summary of COVID-19 Health and Welfare Provisions 27

4.2.4 Inconsistency 30

5 Discussion *33*

5.1 Eligibility Issues for Migrants **33**

5.2 Other Barriers to Access **34**

5.3 State Variances and Practices **35**

6 Recommendations ***36***

7 Conclusions ***37***

8 Limitations ***38***

References ***39***

Annexes ***43***

Abbreviations

CARES Act	Coronavirus Aid, Relief, and Economic Security Act
CHC	Community Health Center
CHIP	Children’s Health Insurance Program
CMS	Center for Migration Studies
DACA	Deferred Action for Childhood Arrivals
DHS	Department of Homeland Security
FFCRA	Families First Coronavirus Response Act
FPL	Federal Poverty Line
ITIN	Individual Taxpayer Identification Number
IRS	Internal Revenue Service
KFF	Kaiser Family Foundation
LPR	Lawful Permanent Resident
NILC	National Immigration Law Center
PRWORA	Personal Responsibility and Work Opportunity Reconciliation Act
PRUCOL	Permanently Residing Under the Color of the Law
SNAP	Supplemental Nutrition Assistance Program
SSI	Supplemental Security Income
SSN	Social Security Number
TANF	Temporary Assistance for Needy Families
TPS	Temporary Protected Status
UI	Unemployment Insurance
US	United States
USCB	United States Census Bureau
USCIS	United States Citizenship and Immigration Services
UN	United Nations
WHO	World Health Organization
WIC	Special Supplemental Nutrition Program for Women, Infants, and Children

Executive Summary

Since the beginning of the Coronavirus pandemic, 6,047,692 total cases, and 184,083 total deaths have been reported in the United States (U.S.) as of September 2, making it one of the hardest hit nations in the world. (1) The pandemic has pointed out both the critical role that migrants have within the U.S. economy, and the migrant-exclusive welfare system currently in place. Making up 18.3% of essential workers, but only 13.7% of the population, migrants have been overrepresented in essential critical infrastructure sectors during the pandemic. (2) Migrants have also been disproportionally effected by job loss caused by the pandemic, seeing a 30% rise in unemployment as compared to 17% in the native-born population. (3) Because of this, it is especially important to ensure that migrants have access to government provided health and social welfare benefits during this time. For this reason, a policy review was conducted to both describe migrant legal access to these benefits prior to the pandemic, and to analyze the policies enacted during the pandemic to determine if migrants have sufficient access to aid programs intended to lessen the effects of the crisis on the general U.S. population. What was found by the study was a complex and fragmented public benefits system, both prior to and during the Coronavirus pandemic. This system not only excludes many foreign-born citizens from accessing essential aid but keeps many more eligible migrants from participating in benefits program due to the complexity and variances in legal access depending on state and federal requirements. In summation, more inclusive and comprehensive policies need to be adopted in order to ensure that this significant and crucial portion of the population has equal and equitable access to the care they need.

1 Introduction

1.1 Migration in the U.S.

The term "migrant" holds many different definitions and weight, but regardless of how one defines migrant or their opinion on migration in itself, it is impossible to deny the influence that the foreign-born population has had in the U.S. The United States Census Bureau (USCB) estimated 44,728,721 foreign-born to be living in the U.S. as of 2018, making up 13.7% of the total population and accounting for one-fifth of the world's migrants, making it home to more migrants than any other nation. (2,4,5) Of this number, 22,629,737 (50.6%) are naturalized citizens, and 22,098,984 (49.4%) are not citizens. (6)

1.2 Migration and COVID-19

Migrants have consistently played an important role in U.S. economic success. As labor force participation rates in foreign-born have long been higher than those of native-born, the U.S. is dependent on migrants for both skilled and unskilled labor. In the context of the COVID-19 crisis, migrants have been equally important, if not more important than before. Based on the U.S. Department of Homeland Security (DHS) "essential critical infrastructure" categories, it has been found that migrants are working disproportionately across all professions. Compared to the 13.7% that migrants comprise of the U.S. population, they are estimated to make up 18% of essential workers during the Coronavirus pandemic. These categories include professions such as health, manufacturing, services, food, and safety, among others. (2)

An estimated 69% of all immigrants in labor force, and an even more noteworthy 74% of undocumented workers are considered essential workers during the pandemic (as compared to 65% of native-born workers). (2) The Center for Migration Studies (CMS) has estimated that there are currently 19.8 million immigrants working in "essential critical infrastructure" categories. (7) Furthermore, while representing 17% of civilians working in 2018, all categories of migrants are estimated to make up 29% of physicians, 38% of home health aides, and 23% of all retail pharmacists. Migrants have been on the frontlines of the fight against coronavirus since the beginning and are vital in both health and non-health related categories, making them essential in both the health and economic response to the pandemic. (8)

Foreign-born Essential Workers in the United States, by Legal Status (2018)				
	Naturalized	**Legal Resident**	**Undocumented**	**Foreign-Born Share of Essential Work**
Total foreign-born essential workers	9,609,000	4,619,600	5,531,300	18.3
Essential Health Care Operations	2,026,900	635,000	351,600	16.3
Essential Infrastructure	1,045,800	424,700	376,200	21.1
Essential Manufacturing	1,198,800	699,400	857,000	20.8
Essential Wholesale	203,300	112,600	137,200	17.6
Energy	53,900	31,800	30,500	12.5
Essential Retail	1,228,100	745,400	1,085,200	18.4
Essential Services	761,200	461,700	661,100	20.2
News Media	46,700	20,600	16,600	12.2
Financial Institutions	1,020,900	337,100	229,300	14.4
Providers of Basic Necessities to Economically Disadvantaged Populations and Employees at Correctional Facilities	223,300	81,700	38,600	14.8
Construction	799,800	604,100	1,398,500	24.8
Defense	103,700	38,500	0	9.0
Essential Services Necessary to Maintain Safety, Sanitation, and Essential Operations of Residence or Other Essential Businesses	539,600	336,800	342,200	19.1
Vendors that Provide Essential Services or Products, Including Logistics and Technology Support	357,100	90,200	7,300	9.8

Table 1. Foreign-born representation in Essential Critical Infrastructre. (2)

1.3 Problem Statement/Justification

Through a global health/equity lens, the inclusion of migrants in all policies is important in any given circumstance, but in times of crisis becomes even more imperative. As has continuously been shown in research, the discrimination that migrants face at the intersection of class, race, and status has unswervingly caused them to be among the world's most vulnerable. (3,9) This vulnerability is brought to light in all crises, and this pandemic has been no exception.

Migrant living and working conditions, xenophobia, exclusion from host communities, and lack of consideration in policy making greatly inhibit them from successfully participating in society. As has been demonstrated in the crisis that we are all facing, these same factors also inhibit them from successfully coping with both the health and economic implications of the Coronavirus outbreak. (10) Although the pandemic has made the interconnectedness and globalized conditions of our world impossible to ignore, somehow governments are still not including migrants in their COVID-19 policy strategies, and migration status remains a key determinant of health. (11) At the same time that migrants are more vulnerable to poor health, they are also more likely to be excluded from public benefit and welfare programs intended to lift people out of such conditions due to the citizenship requirements attached to them. (10) In times of COVID, marked by its global implications and influence, inclusion of migrants in policy response efforts will be critical for successful recovery.

With 6,047,692 total cases, 184,083 total deaths (Sep. 2), and the number of new cases still rising in many parts of the country, the U.S. has been among the hardest hit by the pandemic. (1) This makes their response in terms of policy and welfare aid to the general public even more critical for the nation's recovery. Their inclusion of migrants in these policies will also be critical given both the contribution that migrants have made and the vulnerability that they face during the crisis, as noted above. (8)

While making up a significant proportion of essential employment categories, migrants in the U.S. also make up a disproportionate percentage of U.S. residents who have been impacted by unemployment due to the COVID-19 outbreak. Although these impacts have been notable for both native and foreign-born alike, due to the precarious working conditions of many migrants, unemployment has risen 30% within the immigrant population as compared to 17% in U.S. born workers since the start of the pandemic. (3) Their presence in essential, frontline industries, in combination with their presence in other industries that have been most greatly impacted by the crisis has created a unique double economic and health burden for migrants in the U.S. (3)

This reality makes migrant access to social safety-nets essential in ensuring recovery from the crisis. The World Health Organization (WHO) stated early on in the pandemic that including migrants in outbreak response and readiness is necessary to successfully control the outbreak. (12) First and foremost, to stop the spread of the virus. Restricting migrant access to care, especially when they make up such a large percentage of the frontline response, could cause migrants to avoid seeking care altogether for fear of the financial implications, or cause them to seek care from already overburdened and underfunded community health care providers. (3) Looking further ahead, as the U.S. economy is dependent on foreign-born workers for its success, how they choose to include them in economic relief aid will have great

implications for how the nation will recover from the economic crisis in the long-term. (8) For this reason, a policy review analyzing migrants' legal access to aid provided in the current COVID-19 legislation is necessary to understand and predict how the nation as a whole will recover from this pandemic.

1.4 Research Objectives

The main objective of this research was to determine whether or not current U.S. public policies responding to the COVID-19 outbreak are inclusive of migrants by analyzing their legal access to services provided. Specifically, this study:

- Reviewed federal policies prior to the pandemic to understand migrant access to welfare programs pre-COVID-19
- Reviewed COVID-19 policies to evaluate migrant access to public benefits during the pandemic to determine migrants' legal entitlement to these services
- Analyzed consistency of federal and state policies both prior to and during COVID-19
- Made recommendations to improve migrant access to health and welfare benefits in the U.S.

2 Terms & Definitions

Migrant, otherwise known as foreign born or alien, has been defined by the USCB as anyone who is not a U.S. citizen at birth, including those who have become U.S. citizens through naturalization, lawful permanent residents (LPRs) or Green Card holders, temporary migrants (such as students), humanitarian migrants, and unauthorized migrants. (13)

Federal Means-Tested Benefits are government assistance programs that provide both monetary and non-cash assistance. (14) These programs provide income-based assistance to people living at or below the federal poverty line (FPL), and are designed to help lessen the effects of poverty on U.S. citizens and their families. (15) Federal means-tested benefits include Supplemental Security Income (SSI), Supplemental Nutrition Assistance Program (SNAP), Temporary Assistance for Needy Families (TANF), Medicaid (healthcare), and the Children's Health Insurance Program (CHIP). (14)

Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA), or 1996 Welfare Reform, was a law enacted in 1996 under the Clinton administration that significantly reduced federal spending on welfare programs. (16) This law imposed citizenship requirements for federal means-tested benefits by establishing two categories of migrants, "qualified" and "unqualified", determining migrants that could access benefits and migrant that could not. (16,17) This law also created a five-year waiting period for qualified migrants, prohibiting them from receiving benefits during their first five years of residency. (18) Migrant eligibility for public programs is still based on this reform today.

Public Charge Law is an inadmissibility test that has been part of U.S. federal immigration law since 1882. (17) The purpose of this law is to identify people trying to enter the U.S., or those already admitted into the U.S. in a temporary visa category seeking to become a naturalized citizen (LPR), who may depend on government benefits as their primary source of support. The test looks at characteristics such as age, health, family status, income and resources, and skills and education. Anyone who is identified as likely at any time to become a "public charge" is generally denied admission and ineligible to become an LPR. This law applies to anyone seeking entry into the U.S. and aliens already residing in the U.S. seeking to extend their nonimmigrant (temporary) visa status or become a naturalized citizen. Public charge determination recently became more strict under the Trump administration, and as of 24 February 2020, is defined as "an alien who has received one or more public benefits, as defined in the rule, for more than 12 months within any 36-month period". (19)

Permanently Residing Under the Color of the Law (PRUCOL), is a category used to determine public benefit eligibility, and refers to noncitizens residing in the U.S. with the knowledge and permission of the United States Citizenship and Immigration Services (USCIS). (20)

3 Methodology

This study used a mixed methodology of descriptive and analytical policy review. A review of both federal and state policies existing prior to COVID-19 was conducted in order to describe benefits already in place by the government, and what migrants' legal access to those services are. Once complete, an analytical review was conducted in order to determine if the legislation passed specifically in response to the pandemic meets both the health and economic needs of the migrant community.

3.1 Federal Analysis

3.1.1 Search Strategy

In order to gain a general understanding of the COVID-19 policy context in the U.S., a general search was conducted. The search strategy used can be found below.

Search Strategy for Federal Policy Review
Key Terms Used: US Coronavirus/COVID-19 Legislation, US Coronavirus/COVID-19 Response, US Federal Policies COVID-19, US State Policies COVID-19

Search Engines: pubmed.gov, congress.gov, whitehouse.gov, ncsl.org, kff.org, ballotpedia.org
Time Period: 1 May 2020 – 1 July 2020
Documents Considered: All official federal and state government actions taken in response to the Coronavirus Pandemic

Table 2. Search Strategy for Federal Policy Review.

Given the extensiveness of government actions, such as proclamations, memorandums, and executive orders in response to the pandemic, and the time limitations of this study, it was determined that only bills enacted into law found on the official congress website (congress.gov) would be included for this analysis. Once determined, all legislations enacted from 20 January 2020 (first confirmed case in the U.S.) up to 1 July 2020 were considered.

3.1.2 Inclusion and Exclusion Criteria

Primary data (official government documents/bills) were analyzed to determine different policy components and what impacts these policy aspects could have on migrants. Given the extensiveness of policies in response to COVID-19, a set of inclusion criteria was created to determine what policy aspects to include in this analysis. Policy aspects were included if they provided a specific health or welfare service to the general U.S. population in response to the Coronavirus pandemic. Policies were excluded that provided no specific health or welfare service to the general public, were too vague to determine if they would have an impact on migrants or provided additional funding to already enacted legislation. Based on these criteria, a list of questions was created to analyze the identified documents.

Question:	**Yes/No**
1) Does the policy provide a specific health service to the general U.S. population in relation to the Coronavirus Pandemic?	
2) Does the policy provide a specific welfare service to the general U.S. population in relation to the Coronavirus Pandemic?	
3) Could this policy have a direct effect on migrants currently residing in the U.S.?	

Table 3. Inclusion Criteria for Federal Policies Reviewed.

Both the Coronavirus Preparedness and Response Supplemental Appropriations Act and the Paycheck Protection Program and Health Care Enhancement Act were excluded from analysis for the purposes of

this study. The Coronavirus Preparedness and Response Supplemental Appropriations Act was excluded because there were no specific health or welfare services provided, and the provisions in this legislation offered broad and generalized funding towards the Coronavirus response efforts, such as research and development and worker-based training. The Paycheck Protection Program and Health Care Enhancement Act was excluded from this analysis as well, as most of the provisions in this legislation are either elaborating on or adding funding to policies established in prior legislation, so legal access will not change.

It was determined that the Families First Coronavirus Response Act (FFCRA) and Coronavirus Aid, Relief, and Economic Security (CARES) Act fit the criteria established for this study. Once these documents were determined, migrants' legal access to the benefits provided were considered, including whether or not usage of the benefit would have an effect on public charge determination. It was quickly determined that migrant access to services provided specific to COVID-19 was greatly dependent on their access to federal benefits programs existing prior to the pandemic. Given this, it was determined that a descriptive analysis of the main federal means-tested benefit programs was necessary to fully understand the legal access of migrants to COVID-19 policy benefits.

3.1.3 Assessing Migrant Access to Benefits

In order to assess the inclusivity of laws enacted, a list of criteria was created to categorize policy components from most to least inclusive of migrants. These criteria were adopted from previous research analyzing immigration policies in the U.S., as the coding scheme used was applicable to this study. (21) Once identified, codes applying to health and social welfare policies were adapted to this study. These criteria were applied to both federal means-tested benefits access pre-COVID-19 and access to benefits enacted Coronavirus legislation. These criteria can be found below.

Available to *all* categories of migrants	Available to qualified and some non-qualified migrants	Available to lawfully present pregnant women *and/or* children *during* 5-year ban	Available to certain categories of qualified migrants *during* the 5-year ban	Only available to qualified migrants *after* the 5-year ban

Table 4. Criteria for Federal Policy Analysis.

3.2 State Analysis

3.2.1 Search Strategy

A similar search strategy as that used for the federal analysis was used to assess COVID-19 policies at the state level. Similar search terms were used to find state actions addressing the crisis, and official government laws enacted in response were taken into account.

Search Strategy for State Policy Review
Key Terms Used: US Coronavirus/COVID-19 Legislation, US Coronavirus/COVID-19 Response, US State Policies COVID-19, US State Actions in Response to Coronavirus
Search Engines: pubmed.gov, kff.org, ncsl.org, nilc.org, 9allotpedia.org
Time Period: 1 May 2020 – 1 July 2020
Documents Considered: All official state government actions taken in response to the Coronavirus Pandemic

Table 5. Search Strategy for State Policy Review.

3.2.2 Inclusion and Exclusion Criteria

State policies were considered for review based on the same set of inclusion criteria used for the federal analysis. Those providing specific health or welfare services to the general public in response to the pandemic were considered, and those providing no specific health or welfare service and those too vague to determine potential impact on migrants were excluded. Once relevant documents were determined, the policies which addressed health and welfare of migrants were compared to federal policies which addressed similar issues.

Question:	Yes/No
1) Does the policy provide a specific health service to the general U.S. population in relation to the Coronavirus Pandemic?	
2) Does the policy provide a specific welfare service to the general U.S. population in relation to the Coronavirus Pandemic?	
3) Could this policy have a direct effect on migrants currently residing in the U.S.?	

4) Does this policy aspect address a similar issue as policies considered in federal analysis?	

Table 6. Inclusion Criteria for State Policies Reviewed.

3.2.3 Assessing Migrants Access to Benefits

The same criteria established to assess the inclusivity of laws enacted at the federal level were applied to laws at the state level, adapted from the previous policy analysis, and can be found below in Table 7.

Available to *all* categories of migrants	Available to qualified and some non-qualified migrants	Available to lawfully present pregnant women *and/or* children *during* 5-year ban	Available to certain categories of qualified migrants *during* the 5-year ban	Only available to qualified migrants *after* the 5-year ban

Table 7. Criteria for State Policy Analysis.

3.3 Assessing Inconsistency of Policies

Inconsistency of federal and state policies, both means-tested and COVID-19, was also assessed. In order to quantify the difference between each policy for the analysis, each level of inclusivity established in the criteria used to analyze migrant legal access to benefits was assigned a number.

Available to *all* categories of migrants	1
Available to qualified and some non-qualified migrants	2
Available to lawfully present pregnant women *and/or* children *during* 5-year ban	3
Available to certain categories of qualified migrants *during* the 5-year ban	4
Only available to qualified migrants *after* the 5-year ban	5

Table 8. Grading Used for Criteria.

Once numbers were assigned to each category, the average difference between federal policy and each state policy was calculated.

Example:

SNAP	
Federal Policy	5
California State Policy	4
Average Difference	1

Table 9. Example of System Used to Assess Inconsistency of Policies.

This method was used for each benefit category to determine inconsistency amongst federal and state policies. Inconsistency has been represented using a table similar to that used to demonstrate migrant legal access to services. Each average difference was assigned a color, as shown in the table below. Categories have been adapted from another study evaluating policy consistency that was applicable to this analysis, as it provided definitions and indicators for each consistency category. (22)

Complete consistency	0
Strong consistency	1
Moderate consistency	2
Weak consistency	3
Inconsistent	4

Table 10. Color System Used to Demonstrate Inconsistency of Policies.

4 Results

Decision making in the U.S. is complex as power is divided between the federal, state, and local governments, creating a mix of layers that overlap and interact with each other. While both federal and state governments are modeled in the same way, each state has their own constitution which is intended

to give more sovereignty and autonomy to states so that they can better meet the needs of their community. (23)

Furthermore, power in the U.S. is divided into two categories; exclusive powers, in which lawmaking can only be done at either the federal or the state level, and concurrent powers, meaning that decision making is shared amongst federal and state governments. While states must abide by federal mandates, they can use concurrent power to create additional laws and services within their community. In terms of health and welfare benefits, this means that while the federal government provides funding and grants for programs, states can use their own funding to provide additional services, or take certain services away, based on perceived need. This system has resulted in a complex health and social welfare benefits system, as policies can vary not only from state to state, but also from different areas within each state. (23,24)

In this study, two main benefits will be discussed; federal means-tested benefits and COVID-19-specific benefits. Federal means-tested benefits are income-based social welfare services provided to U.S. citizens living at or below FPL. Both means-tested benefits and the COVID-19 specific benefits looked at in this study provide cash assistance, food assistance, and healthcare to individuals and families. (15)

4.1 Federal Means-Tested Benefits

There are five federal means-tested benefits (SSI, SNAP, TANF, Medicaid, and CHIP). These benefits fall into two categories; income security and health programs, and can provide both direct cash or non-cash assistance. (15) These benefits are intended to provide a safety net to lessen the effects of poverty on low-income citizens. (14) I have chosen to analyze them for this study due to the fact that much of the direct aid provided to American citizens in the coronavirus legislation was allocating additional funding to these programs, so understanding migrant eligibility and legal access to these means-tested benefits is critical in understanding their access during COVID-19. Table 11 provides a brief overview of each benefit program. (19,25–30)

Also included in the table is public charge consideration. Public charge law is used in U.S. migration policy to determine whether or not foreign-born citizens can qualify for entry and/or citizenship in the U.S. It analyzes the likelihood of individuals seeking entry into the U.S., or individuals with temporary visa status seeking to become a citizen, of depending primarily on government benefits for support. (19) With the recent changes made to this law, use of one or more pubic benefits for more than 12 months within any 36-month period can result in denial of entry and citizenship in the U.S., and even deportation. (31) It has been included in this analysis as the recent changes made to the law has greatly impacted migrant usage of benefits, both prior to and during the pandemic, and is an important aspect to take into consideration when assessing legal access of migrants to benefits.

Federal Means-Tested Benefits
Supplemental Security Income (SSI)
A needs-based program that provides cash benefits designed to ensure a minimum income to aged, blind, or disabled persons with limited income and assets **Considered in Public Charge Analysis:** YES
Supplemental Nutrition Assistance Program (SNAP)
Provides benefits to eligible low-income individuals and families via an Electric Benefits Transfer card, which can be used like a debit card to purchase eligible food in authorized retail food stores **Considered in Public Charge Analysis:** YES
Temporary Assistance for Needy Families (TANF)
Designed to help needy families achieve self-sufficiency. States receive block grants to design and operate programs to meet any of the four goals: (1) provide assistance to needy families so that children may be cared for in their own homes or in the homes of relatives; (2) end the dependence of needy parents on government benefits by promoting job preparation, work, and marriage; (3) prevent and reduce the incidence of out of wedlock pregnancies and establish annual numerical goals for preventing and reducing the incidence of these pregnancies; and (4) encourage the formation and maintenance of two-parent families **Considered in Public Charge Analysis:** YES
Full-Scope Medicaid
Provides health coverage to eligible low-income adults, children, pregnant women, elderly adults and people with disabilities. Medicaid is administered by states, according to federal requirements. The program is funded jointly by states and the federal government. • **Considered in Public Charge Analysis:** YES (unless a pregnant woman or woman within 60-day period beginning on the last day of the pregnancy or a child under the age of 21)
Children's Health Insurance Program (CHIP)
A joint federal and state program that provides health coverage to uninsured children in families with incomes too high to qualify for Medicaid, but too low to afford private coverage **Considered in Public Charge Analysis:** NO

Emergency Medicaid
Available to individuals who are otherwise eligible for Medicaid, except for their immigration status (such as some people with temporary protected status (TPS), Deferred Action for Childhood Arrivals (DACA), or people with lawful permanent resident status who have had that status for less than five years), and undocumented people). Emergency Medicaid covers "a medical condition (including emergency labor and delivery) manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in (A) placing the patient's health in serious jeopardy, (B) serious impairment to bodily functions, or (C) serious dysfunction of any bodily organ or part. **Considered in Public Charge Analysis:** NO

Table 11. Summary of Federal Means-Tested Benefit Programs and Their Public Charge Implications.

4.1.1 Migrant Qualification

The current criteria in accessing federal benefits are based on the Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA) of 1996. (18) This act significantly changed federal aid to the poor, but also made two important changes for migrants trying to access benefits.

The first thing that PRWORA did was establish two separate classifications of migrants; "qualified" and "unqualified", defining specific categories of migrants that could be eligible for benefits and specific groups that could not. (17) Prior to 1996, foreign-born citizens generally had the same requirements for welfare programs as native-born, but following this reform migrants had to fall into specific categories in addition to meeting previously established income requirements to qualify for benefits. (17) An overview of the federally established criteria can be found in Table 5. (17,18)

"Qualified Immigrant"	
-LPRs -Refugees -Asylees -Persons paroled into the U.S. for at least one year -Persons granted withholding of deportation or removal -Persons granted conditional entry (before April 1, 1980) Battered spouses and children (with a pending or approved spousal visa or a self-petition for relief under the Violence Against Women Act)	-Cuban and Haitian entrants (nationals of Cuba and Haiti who were paroled into the United States, applied for asylum, or are in exclusion or deportation proceedings without a final order) -Victims of severe human trafficking (since 2000, victims of trafficking and their derivative beneficiaries [e.g., children], are eligible for federal benefits to the same extent as refugees/asylees)

"Unqualified Immigrant"	
-Lawfully present immigrants (students, tourists...) -Persons with temporary protected statuses (asylum applicants)	-Unauthorized immigrants -Immigrants formerly considered permanently residing under color of law (PRUCOLs)

Table 12. Migrant Benefit Qualifications.

The second key change that the welfare reform of 1996 created was a five-year waiting period for qualified migrants to be able to access public benefits. (16) This five-year waiting period meant that after 1996, "qualified" migrants had to wait five years, maintaining their qualified status, in order to be able to access those benefits. This waiting period also applies to migrant women and children, and has had great impact on the otherwise eligible, low-income migrants living in the U.S. (32) Some exception to the five-year ban have been established. Although varying slightly from benefit-to-benefit, the key exceptions can be found below in Table 6.

Exemptions from 5-year ban
-Refugees, asylees, and other immigrants exempt on humanitarian grounds -Members of the military and veterans (and their spouses and children) -LPRs with 40 qualifying quarters of work

Table 13. Foreign-Born Exempt from 5-year Ban.

4.1.2 Overview of Migrant Eligibility for Means-Tested Benefits from State-to-State

Table 15 was created summarizing the inclusivity of migrants in federal means-tested health and welfare benefits. Results are based on the pre-established criteria below and range from completely inclusive of all migrants, regardless of immigration status (darkest green), to only available to those migrants that are both qualified and have completed the five-year bar. Additionally, certain states have chosen to adopt more restrictive policies than those established in federal guidelines, which can also be found in the tables below. A detailed summary of state variations in legal access to means-tested programs can be found in Annexes 1-5.

Available to *all* categories of migrants	Available to qualified and some non-qualified migrants	Available to lawfully present pregnant women *and/or* children *during* 5-year ban	Available to certain categories of qualified migrants *during* the 5-year ban	Only available to qualified migrants *after* the 5-year ban

Table 14. Criteria Used for Policy Analysis.

Federal Means-Tested Benefits						
	SSI	SNAP	TANF	Full-Scope Medicaid	CHIP	Emergency Medicaid
Alabama (AL)						
Alaska (AK)						
Arizona (AZ)						
Arkansas (AR)						
California (CA)						
Colorado (CO)						
Connecticut (CT)						
Delaware (DE)						
District of Columbia (DC)						
Florida (FL)						
Georgia (GA)						
Hawaii (HI)						
Idaho (ID)						
Illinois (IL)						

Indiana (IN)						
Iowa (IA)						
Kansas (KS)						
Kentucky (KY)						
Louisiana (LA)						
Maine (ME)						
Maryland (MD)						
Massachusetts (MA)						
Michigan (MI)						
Minnesota (MN)						
Mississippi (MS)						
Missouri (MO)						
Montana (MT)						
Nebraska (NE)						
Nevada (NV)						
New Hampshire (NH)						
New Jersey (NJ)						
New Mexico (NM)						
New York (NY)						
North Carolina (NC)						

North Dakota (ND)						
Ohio (OH)			denies TANF to most "qualified" immigrants, even after they complete the federal 5-year bar			
Oklahoma (OK)						
Oregon (OR)						
Pennsylvania (PA)						
Rhode Island (RI)						
South Carolina SC)						
South Dakota (SD)						
Tennessee (TN)						
Texas (TX)				denies federal Medicaid to most "qualified" immigrant adults, even after they complete the federal 5-year bar		
Utah (UT)						
Vermont (VT)						

Virginia (VA)						
Washington (WA)						
West Virginia (WV)						
Wisconsin (WI)						
Wyoming (WY)				denies Medicaid to most nonpregnant lawful permanent residents who do not have credit for 40 quarters of work history in the U.S.		

Table 15. Summary of Inclusivity of Migrants in Means-Tested Benefits State-by-State.

4.1.3 State Variances

As mentioned previously, state, and even local governments, have autonomy in the policy making process. Although required to provide at least the minimum amount of services as laid out by the federal government (using federal funding), each state can chose to provide additional services using state-only funding. (17) While some states have used this as an opportunity to expand the safety-net to migrants, it has also resulted in great complexity and confusion about the benefits system, and who qualifies for which benefits. (18)

An underwhelming number of states have chosen to provide state-only cash and food assistance to migrants ineligible under federal programs. Five states (CA, HI, IL, ME, and NH) provide SSI replacement to certain additional categories of "qualified" migrants. (33) Similar in numbers, six states (CA, CT, IL, ME, MN, and WA) provide SNAP replacement. (34) Thirty-six states have elected to provide the state-option established in 2017 to provide healthcare to all children and pregnant women, regardless of immigration status, using Medicaid and CHIP programs. Coverage generally includes prenatal and postnatal care up to 60 days for women and care for the child up to 19 or 21 years of age depending on the state. While this number is significant, given the fact that the federal government offers funding to provide this option, there is no reason that all 51 states should not elect for it. (32)

In terms of who is eligible under state-funded programs, though varying from state-to-state, some key themes can be identified. Overall, of those states choosing to provide more extensive public services to migrants, "qualified" migrants ineligible for federal programs due to the welfare reform are the most common group included in state-identified categories. Other categories most frequently added at the state-level include; PRUCOLS, the elderly (with age cap varying from state-to-state), humanitarian migrants, (i.e. victims of trafficking, crime, domestic violence, and abuse), the disabled, and those awaiting certain application approval, such as employment and asylum. Interesting to note, only refugees whose application process has been approved are eligible for federal benefit programs, meaning that, unless states chose to adopt more inclusive policies, asylum seekers who are legally present, but waiting on application approval, cannot receive benefits. (33–37)

Regarding healthcare, certain states have opted to either 1) cover additional groups of migrants with Medicaid or 2) provide treatment for certain medical conditions regardless of migration status. Coverage to additional groups greatly mirrors those mentioned above but qualifying medical conditions differ drastically from state-to-state. Some examples of qualifying conditions include terminal illness, cancer, diabetes, hypertension, and end-stage renal failure. (36)

Contrarily to the more inclusive options many states have chosen, some states have used their autonomy to opt towards more exclusivity of migrants in their policies, denying them services that they would be qualified for under federal law. For example, Texas does not provide Medicaid to qualified migrants, even after the five-year waiting period. Similarly, the state of Wyoming denies Medicaid to any migrant who does not have 40 quarters of work history in the U.S. (36) The state of Ohio also bans all qualified migrants from receiving TANF benefits. (35)

4.1.4 Inconsistency

Table 17 provides a summary of the inconsistency of each state policy with corresponding federal policies for means-tested benefits. These results have been obtained using the criteria established below in Table 16. Categories range from white (completely consistent with federal policies) to dark blue (inconsistent with federal policies), meaning that the darker the shade of blue, the more inconsistency between policies.

Complete consistency	0
Strong consistency	1
Moderate consistency	2
Weak consistency	3

Inconsistent	4

Table 16. Color System Used to Demonstrate Inconsistency of Policies.

Federal Means-Tested Benefits						
	SSI	SNAP	TANF	Full-Scope Medicaid	CHIP	Emergency Medicaid
AL						
AK						
AZ						
AR						
CA						
CO						
CT						
DE						
DC						
FL						
GA						
HI						
ID						
IL						
IN						
IA						
KS						
KY						
LA						
ME						

MD						
MA						
MI						
MN						
MS						
MO						
MT						
NE						
NV						
NH						
NJ						
NM						
NY						
NC						
ND						
OH						
OK						
OR						
PA						
IR						
SC						
SD						
TN						
TX						
UT						
VT						

VA						
WA						
WV						
WI						
WY						

Table 17. Summary of Inconsistency of Means-Tested Benefits State-by-State.

4.2 COVID-19 Benefits

4.2.1 Coronavirus Legislation in Response to COVID-19

There have been four main legislations enacted at the federal level in response to the Coronavirus Pandemic in the U.S. A timeline and summary of these bills can be found below in Table 18. (38)

Summary of Key Legislation Enacted in Response to the Coronavirus Pandemic in the U.S.	
Coronavirus Preparedness and Response Supplemental Appropriations Act, 2020	
March 6th, 2020	This bill provides $8.3 billion in emergency funding for federal agencies to respond to the coronavirus outbreak both domestically and internationally. Funding is divided amongst the following: developing, manufacturing, and procuring vaccines and other medical supplies; grants for state, local, and tribal public health agencies and organizations; loans for affected small businesses; evacuations and emergency preparedness activities at U.S. embassies and other State Department facilities; and humanitarian assistance and support for health systems in the affected countries.
Families First Coronavirus Response Act (FFCRA)	
March 18th, 2020	This bill responds to the COVID-19 outbreak domestically by providing paid sick leave for employees, tax credits to reimburse employers for paid sick and family medical leave, and free COVID-19 testing; expanding food assistance and unemployment benefits; and increasing Medicaid funding.
Coronavirus Aid, Relief, and Economic Security (CARES) Act	

March 27th, 2020	This bill provides over $2 trillion in economic relief with the aim of protecting the American people from the public health and economic impacts of COVID-19 by providing economic impact payments to workers and families, small business loans, and assistance for state, local, and tribal governments.
Paycheck Protection Program and Health Care Enhancement Act	
April 24th, 2020	This bill responds to the COVID-19 outbreak by providing additional funding to the Paycheck Protection Program (established by the CARES Act), health care providers, and COVID-19 testing.

Table 18. Summary of Main Legislature Enacted in Reponse to COVID-19.

As mentioned previously, the Families First Coronavirus Response Act (FFCRA) and Coronavirus Aid, Relief, and Economic Security (CARES) Act will be the main focus of the analytical policy review, as these are the two main legislations that directly provide public benefits to the general population during the pandemic.

Within both of these legislations, specific acts addressing different policy components related to the pandemic are laid out. For simplification, those policy components identified as relevant to this study based on inclusion criteria have been divided into four categories based on the services provided; income security, health, employment, and nutrition. Categories were created by the author and were intended to be as consistent as possible with Means-Tested benefit categories. A table of all of the policy components identified as having potential to impact migrants have been divided amongst these categories and can be found below (Table 19). Corresponding legislature can be found in brackets.

A) Income Security	Recovery Rebate [CARES – Subtitle B, Sec. 2201]
B) Health	Coronavirus Testing [FFCRA – Division F] [CARES – Part II, Subpart A]
C) Employment	Emergency Family and Medical Leave Expansion Act (FMLA) [FFCRA – Division C], Emergency Unemployment Insurance Stabilization and Access Act [FFCRA – Division D], Emergency Paid Sick Leave Act [FFCRA – Division E], Pandemic Emergency Unemployment Compensation [CARES – Subtitle A, Sec. 2107], Pandemic Unemployment Assistance [CARES – Subtitle A, Sec. 2101], Keeping American Workers Paid and Employed Act [CARES – Division A, Title I]

D) Nutrition	Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) [FFCRA – Division A, Title I], Emergency Food Assistance Program (TEFAP) [FFCRA – Division A, Title I], Supplemental Nutrition Assistance Program (SNAP) [FFCRA – Division A, Title II], Nutrition Assistance (grants to the Northern Mariana Islands, Puerto Rico, and American Samoa) [FFCRA – Division A, Title I], Administration for Community Living (nutrition services) [FFCRA – Division A, Title V], Maintaining Essential Access to Lunch for Students Act or the MEALS Act [FFCRA – Division B, Title I], COVID-19 Child Nutrition Response Act [FFCRA – Division B, Title II], Supplemental Nutrition Assistance Program (SNAP) Waivers [FFCRA – Division B, Title III], Child Nutrition Programs (Federal school breakfast and lunch programs) [CARES – Division B, Title I]

Table 19. Identified COVID-19 Federal Policy Aspects for Review.

4.2.2 Overview of Migrant Access to COVID-19 Benefits

The inclusivity of COVID-19 benefits in each state was assessed using the same set of criteria as that used for federal means-tested benefits. Results can be found below in Table 20.

COVID-19 Benefits				
	Income Security	Health*	Employment**	Nutrition***
AL				
AK				
AZ				
AR				
CA				
CO				
CT				
DE				
DC				
FL				

GA				
HI				
ID				
IL				
IN				
IA				
KS				
KY				
LA				
ME				
MD				
MA				
MI				
MN				
MS				
MO				
MT				
NE				
NV				
NH				
NJ				
NM				
NY				
NC				
ND				
OH				

OK				
OR				
PA				
IR				
SC				
SD				
TN				
TX				
UT				
VT				
VA				
WA				
WV				
WI				
WY				

Table 20. Summary of Inclusivity of Migrants in COVID-19 Benefits State-by-State.

*Health access dependent on previous state criteria

**All migrants have access to employment benefits regardless of immigration status under FFCRA, but must be work authorized for employment benefits under CARES Act (excludes undocumented)

***All migrants have access to nutrition benefits created under COVID-19 legislation regardless of migration status, those provided under SNAP dependent on previous state criteria

4.2.3 Summary of COVID-19 Health and Welfare Provisions

A) Economic Security

The CARES Act provided individual taxpayers with a one-time, refundable income tax credit (Recovery Rebate) of $1,200, or $2,400 for married couples filing a joint return. Individuals can also receive a $500 credit for each qualifying child. This rebate is not income-based but does place a cap for those exceeding a certain income (taxpayer's whose adjusted gross income exceeds (1) $150,000 in the case of a joint return, (2) $112,500 in the case of a head of household, and (3) $75,000 in the case of a taxpayer not

described in (1) or (2)). The rebate is based on individuals' most recent tax returns and was issued automatically. (39)

In terms of migrant eligibility, the act excluded "any nonresident alien individual" from receiving the rebate, barring all foreign-born who are not LPRs. (39) There is also a Social Security Number (SSN) requirement to receive the financial aid, meaning that although a migrant may be legally present and paid taxes, if they filed their taxes with an Individual Taxpayer Identification Number (ITIN) and not a SSN, they did not receive the rebate[1]. (40)

These requirements have extremely limited the number of migrants with legal access to the Recovery Rebate. Additionally, for mixed-migration status married taxpayers who filed jointly for their taxes, if one taxpayer filed with an SSN, but the other filed with an ITIN, they are no longer eligible for the rebate. Children claimed for the rebate must also have valid SSNs to receive the $500 credit. (40) Both California and New York City have enacted additional cash assistance programs to unauthorized immigrants ineligible for the federal rebate. (41)

B) Health

Healthcare provisions in U.S. Coronavirus legislation are arguably the most difficult to assess in terms of migrant access. More directly impacting migrants, one of the main steps that the U.S. government has taken in addressing the sanitary crisis is providing free coronavirus testing and testing-related services under Medicaid, notably including to uninsured persons. (40) Although this will undoubtedly have a positive impact on the general U.S. population, it is important to note that none of the legislation passed up to this point in the pandemic has changed migrant eligibility to health programs, meaning that only those qualifying for Medicaid and CHIP programs in their prospective state prior to the pandemic have access to this free testing. (30,40)

Although direct COVID-19 provisions are somewhat restrictive towards migrants, what it is equally as important to note is the indirect impact that coronavirus bill financing could potentially have on the foreign born. Billions of dollars in aid have been provided to Community Health Centers (CHC) to reimburse testing and treatment costs. (42,43) As CHC are able to provide care regardless of immigration status or ability to pay, this provision is crucial for to the migrant community. (40) While this has allowed many states and health centers to provide additional care to migrants, the actual legal entitlement of migrants to these services is insufficient and does not go far enough to protect migrants from the health crisis, as access to care is based on the availability and willingness of providers to give it.

States have also been granted further flexibility and funding in terms of testing, treatment, and service provision under new legislation, so depending on how states have chosen to use that freedom also impacts migrants' legal access to health care services. For example, under Emergency Medicaid, all migrants are able to receive care regardless of immigration status. Twelve states (CA, CO, CT, DE, MA, ME,

[1] An ITIN is a tax processing number only available for certain nonresident and resident aliens, their spouses, and dependents who cannot get an SSN. Non-citizens must request an SSN card as part of their immigrant visa application and be an LPR. Refugees cannot apply. (54,55)

MI, NV, NY, OR, PA, WA) have currently chosen to cover COVID-related testing and treatment through emergency Medicaid, including it as a qualifying emergency medical condition during the pandemic. (44)

C) Employment

Both the FFCRA and the CARES Act allocated a significant amount of funding to provide employment aid to citizens in an effort to reduce the economic impact of the pandemic. The FFCRA created the Emergency Family and Medical Leave Expansion Act, the Emergency Unemployment Insurance Stabilization and Access Act, and the Emergency Paid Sick Leave Act. (43,45) Under the CARES Act the Pandemic Emergency Unemployment Compensation, Pandemic Unemployment Assistance, and Keeping American Workers Paid and Employed Act were created. (39,42)

The Emergency Family and Medical Leave Expansion Act "permits employees to take public health emergency leave through December 31, 2020, to care for the employee's child during a COVID-19 (i.e., coronavirus disease 2019) public-health emergency". (45) Employers with less than 500 workers are required to provide up to 12 weeks of paid leave to employees who cannot work due to childcare necessities caused by the pandemic. Furthermore, employers are required to allow the employee to return to their position following the paid leave. (43) There are no eligibility requirements in relation to migrants to receive this benefit, so any migrant that has been employed for more than 30 days has access to this benefit. As emergency leave is provided directly from employers to employees, reception of paid leave will not count towards public charge ruling. (40)

The Emergency Paid Sick Leave Act requires employers to provide employees unable to work due to COVID-19 with paid sick leave. All full-time employees are entitled to 80 hours of paid sick time (two full weeks) in order to quarantine or take care of their child due to school closures. (45) Similar to the Emergency Family Medical Leave Expansion Act, there are no restrictions for migrants to access paid sick leave and does not count towards public charge, as all interaction is done between employee and employer. (40)

The Emergency Unemployment Insurance Stabilization Act provides emergency grants in order to fund state unemployment programs. For migrants to be able to access these benefits they have to be work authorized when they file for benefits and be a permanent resident under PRUCOL. As unemployment insurance is an earned benefit, it is not counted in public charge determination.

Adding onto the Unemployment Insurance (UI) established in the FFCRA, the CARES Act established both the Pandemic Emergency Unemployment Compensation and Pandemic, Unemployment Assistance, which both increase benefits provided by previously established UI, and create new programs to cover those ineligible for previous UI programs or that had already used all available benefits. (39,40) For migrants to be able to receive unemployment benefits established in either legislation, they must be work authorized at the time they file for benefits and legally residing under PRUCOL, meaning that all foreign born apart from undocumented migrants qualify for the benefit. (40)

D) Nutrition

Ensuring that children and their families continue to receive proper nutrition assistance during the pandemic was one of the main focuses of coronavirus legislation. This was approached by both increasing funding allocated towards government nutrition programs, and by creating waivers to be able to extend program coverage scope to more affected people. (39,45)

In regards to funding, the FFCRA and CARES act provided over $25 billion towards Special Supplemental Nutrition Program for Women, Infants, and Children (WIC), the Emergency Food Assistance Program, SNAP, general nutrition assistance to the Northern Mariana islands, Puerto Rico, and the American Samoa, and other Coronavirus nutrition programs. (39,45,46)

New under coronavirus legislations were the MEALS and COVID-19 Child Nutrition Response Act. Both of these acts focus on the nutrition of children and families affected by school closures and waive previous school nutrition program requirements to provide food services outside of the educational institution to ensure that all children have access to adequate food and nutrition. These acts established meal replacement benefits for household that would have received free or reduced-price meals at schools depending on their income, and also waived congregate feeding requirements to allow home delivery of meals as long as necessary sanitary measures are taken. Additionally, under the FFCRA, states are also given the option to provide SNAP benefits to children who would have otherwise received free and reduced lunches. (45) Of these nutrition assistance programs, SNAP is the only one that is considered negatively charged. (47)

Fortunately, most of the nutritional benefits provided in COVID-19 legislation do not impose any kind of immigration status requirement, so all migrants fulfilling income eligibility have access to the services provided under the MEALS and Child Nutrition Response Acts. Additionally, the meal replacement benefits provided under the MEALS act are available even to those not enrolled in SNAP, meaning that migrant households that may not meet their state eligibility criteria are still able to access nutritional aid during this time. As far as aid provided under SNAP, eligibility is dependent on normal state and federal guidelines, meaning that immigrants must qualify in their state to receive emergency SNAP benefits. (47)

4.2.4 Inconsistency

The inconsistency of COVID-19 benefits with previously established federal policies was assessed using the same criteria as that used for means-tested benefits. Consistency levels range from full consistency with federal policies (white) to inconsistent with federal policies (dark blue). Results can be found below in Table 21.

COVID-19 Benefits				
	Income Security	Health	Employment	Nutrition

AL				
AK				
AZ				
AR				
CA				
CO				
CT				
DE				
DC				
FL				
GA				
HI				
ID				
IL				
IN				
IA				
KS				
KY				
LA				
ME				
MD				
MA				
MI				
MN				
MS				
MO				

MT				
NE				
NV				
NH				
NJ				
NM				
NY				
NC				
ND				
OH				
OK				
OR				
PA				
IR				
SC				
SD				
TN				
TX				
UT				
VT				
VA				
WA				
WV				
WI				
WY				

Table 21. Summary of Inconsistency of COVID-19 Benefits State-by-State.

5 Discussion

5.1 Eligibility Issues for Migrants

Means-tested benefits have been described as a critical resource for American families facing economic difficulties, and seen as "the last line of defense against abject poverty", but the changes made by the 1996 Welfare Reform have created a restrictive system that keeps many migrants from participating. (15) The PRWORA intended to discourage immigrants from taking advantage of U.S. welfare but has resulted in a complex and confusing system that has kept thousands of low-income foreign-born U.S. residents from accessing benefits each year due to the five-year waiting period and other eligibility restrictions placed on migrants.

Looking at healthcare alone, there were an estimated 28.6 million uninsured U.S. residents in 2018. (3) Of those, an estimated 7.7 million were noncitizens (27%), and 4.3 million were unauthorized. (3) In the context of COVID-19, this means that without changing migrant eligibility for these services, many of the people living in the U.S. that the coronavirus legislation is intended to help will still be excluded. This exclusion, in combination with the high costs of private insurance in the U.S., has already resulted in many reports of U.S. residents – both citizens and noncitizens alike – avoiding testing due to the inability to afford it. (3)

In terms of economic contributions, over $13.7 billion in net taxes were paid with ITINs in 2015. (48) Looking specifically at undocumented migrants, approximately $12 billion from payroll taxes were added to Social Security trust funds, and from 2000-2011, undocumented migrants added $35.1 billion more into Medicare (federal health insurance for people 65 and older) then they withdrew. (48,49) Despite these contributions, migrants are almost completely barred from means-tested and COVID-19 monetary benefits due to the SSN requirement. Given the high rates of unemployment, this aid will be critical for many individuals and families during this crisis.

Equally as important to draw attention to in the context of the U.S. is the unauthorized migrant. Of all foreign-born citizens in the U.S., 10.5 million (one-quarter) were estimated to be unauthorized in 2017. (41) Of these unauthorized immigrants, there are over 5.5 million considered essential in the COVID-19 response. (2) Their contribution and influence in the U.S. is quite clear, and what is also clear is their lack of legal entitlement to almost all welfare aid, both pre-COVID and COVID context.

Out of all undocumented migrants, an estimated 7.1 million do not have health insurance due to the lack of legal access to government-provided Medicaid and inability to pay for private coverage. (50) Following federal guidelines, undocumented migrants are also ineligible for SSI, SNAP, and TANF programs, leaving out essentially all aid to low-income undocumented immigrants unless states take individual action to provide services. (41) Although considered unauthorized, almost two-thirds of this population have been residing in the U.S. for over 10 years, which therefore raises the question of at which point does a foreign-born population deserve access to the same services as native-born. (41)

This exclusion of unauthorized migrants in the social safety-net system is not a new phenomenon and has continued on throughout the pandemic. Looking at COVID-19, little has changed in regard to unauthorized migrant access to benefit programs. While positive to note that there are no citizenship requirements for most of the nutrition services offered and paid sick and family leave, undocumented migrants are excluded from all Medicaid expansion and free testing unless states chose to provide testing and treatment under Emergency Medicaid, and excluding a population so large from health and welfare services during a health and economic crisis could have grave consequences for the future. (41)

5.2 Other Barriers to Access

When analyzing migrant legal access and usage of public services in the U.S., especially in times of COVID, the public charge law simply cannot be ignored. As the new law was implemented 24 February 2020, it came just in time for the pandemic, and although its application has been recent, its implications in the migrant community have been visible for some time. (19)

The law has resulted in many migrants disenrolling both themselves and their children or choosing not to renew benefits in fear that it could negatively affect their public charge ruling and disqualify them from citizenship. (3) Referred to as a “chilling effect” this fear around public charge implications has resulted in both decreased enrollment in public programs that are not considered in the public charge ruling (such as CHIP, WIC, and other food assistance programs) and disenrollment by migrants who have already achieved LPR status and are not subject to the law, fearing that they will lose their citizenship or jeopardize that of a family member. (3,51)

One study found that about one in seven adults in migrant families reported chilling effects in regards to government benefit programs. (52) In a separate survey, half of health centers reported a decrease in health service usage among immigrant patients. Usage especially decreased amongst pregnant women, who they found to be initiating prenatal care later in pregnancy and having fewer visits overall, as well as patients with chronic conditions, and patients requiring preventative care. (51) The survey also found that 47% of health centers reported many or some immigrant patients declining to enroll in Medicaid in the past year, 32% said many or some have disenrolled or declined to renew Medicaid coverage, 38% said that many or some were declining to enroll their child over the past year, and 28% reported many or some disenrolling or not renewing for their child. (51)

At the end of March 2020, USCIS posted an alert on their website “encouraging all those, including aliens, with symptoms that resemble Coronavirus 2019 (COVID-19) (fever, cough, shortness of breath) to seek necessary medical treatment or preventive services. Such treatment or preventive services will not negatively affect any alien as part of a future Public Charge analysis”. (31) Many have expressed that this announcement has come too late, and that it is not enough to reverse the fear in migrant communities and encourage them to seek care. (50)

This discouragement of health seeking behaviors is not only dangerous in the context of COVID-19, where fear of seeking care will only continue the spread and severity of the virus. It also speaks to a larger problem that the anti-migration policies and exclusion from welfare programs in the U.S. could cause in the long run; poor and worsening health outcomes. As pregnant women are avoiding care, children are intentionally being kept from essential health and nutrition services, chronic conditions such as HIV/AIDS and diabetes are not being treated, and preventative care is being evaded, if the U.S. does not address the impact the new public charge has had on health and welfare seeking behaviors in migrants, it could see a sharp decline in health within the migrant community. (51) Additionally, health centers have already reported revenue losses due to the decreased number of patients covered by Medicaid, increase in uninsured patients, and overall drop in patient visits. This shows that the decrease in usage of health services is not only significant for the health and livelihood of migrants but could also have negative repercussions for many of the health centers primarily treating migrants and low-income families throughout the U.S. (51)

If anything can be concluded thus far, it is that the fear imposed by the new public charge law is far more influential than any legal right migrants have to public benefit services. Collectively, all countries across the globe have faced the fear of the health and economic impacts of the pandemic, but the anti-migration climate in the U.S. has added another layer of fear around citizenship and deportation that has and will continue to determine migrant usage of public services during this time. Whereas many countries have increased flexibility around migration policies in response to the outbreak in an effort to counteract these fears, the U.S. has continued to enact and enforce restrictive legislation, which will only continue to discourage migrants from seeking care and worsen the effects of the virus in both foreign and native-born communities. (10)

5.3 State Variances and Practices

While the division of federal, state and local government power can be a useful tool to adapt to specific community needs, in the case of migrant access to health and welfare benefits, it has created a confusing, and in some cases contradictory system that keeps many foreign-born/non-citizens from participating. (53) State responsibility to choose whether to restrict migrant access to benefits, to provide more benefits using state funding, and who to provide, or not to provide benefits to has resulted in a complex string of policies, that even staff and professionals have difficulty understanding. (17) Research has found that, although meeting both income and eligibility criteria, immigrant families tend to be less likely than other families to access benefits because of this complexity and fear around use. (18)

This confusion and fear have unfortunately carried over to COVID-19 access. Given that immigrant eligibility for non-emergency Medicaid, CHIP, and SNAP has not changed during the pandemic, migrants face some of the same complexities in accessing health and welfare services as in pre-pandemic context. This, in combination with other state actions during the pandemic, such as whether or not to provide COVID-19 testing, diagnosis, and treatment under Emergency Medicaid, may even result in more confusion than before. (40)

So, although more inclusive than means-tested benefits, COVID-19 policies are much more inconsistent with federal policies, which could lead to even greater uncertainty in eligibility. Given the many barriers, both legal and non-legal, that migrants already face in accessing the benefits system, confusion on eligibility should not be one of them.

6 Recommendations

The pandemic has brought to light many of the weaknesses in the U.S. welfare system in regard to migrant access. Although the division of federal and state power is valuable to be able to adapt to localized needs, there is a need for coordinated federal policies in response to the pandemic to ensure a minimum standard of coverage and care for all individuals living in the U.S. The following recommendations have been made based on the results of this study;

- **Health coverage** – in order to ensure that all individuals residing in the U.S. have access to healthcare services during the pandemic, federal policies needs to either 1) lift Medicaid eligibility requirements for immigrants so that they can access the testing/treatment services provided under Full-scope Medicaid or 2) provide these services under emergency Medicaid, as some states have already elected to do, as there are no citizenship requirements. A successful response to the health crisis cannot be seen until all individuals are covered under healthcare legislation.
- **Income Security** – in order to ease some of the economic impact of the pandemic for migrants, the SSN requirement for the Recovery Rebate must be lifted. Given the high number of foreign-born/mixed-status families that file taxes with an ITIN, there are many migrants – both documented and undocumented – that, although paying taxes, are excluded from the rebate. Additionally, all individuals, both foreign and native-born, who do not earn enough income are not required to file taxes. This means, given that the rebate was issued automatically based on the previous fiscal year's tax filing, those in the U.S. with the lowest income and in greatest need of the rebate did not receive it nor had any way to apply for it. (40) In order to address this issue, some kind of eligibility assessment needs to be created to make the rebate available to all income eligible individuals living in the U.S.
- **Public Charge** – the public charge law needs to be lifted on all means-tested benefits during the pandemic, not just COVID-19 testing and treatment, to protect migrants and ease the fear and confusion around the rule. Given the increased necessity of welfare benefits caused by the health and economic crisis that is being faced, policy makers must ensure that people are not avoiding use simply due to the fear around citizenship implications.

Although these recommendations are specific to COVID-19 legislation, they should be reflective of a larger welfare shift in the U.S. towards a more inclusive and uniform system that encourages the health and well-being of all people living there.

7 Conclusions

As has been demonstrated in many different contexts, the strain placed on already fragile government systems by this pandemic has brought many issues to light. In the case of the U.S., what can be seen now in regard to heath seeking behavior and benefit usage of migrants during the pandemic is a reflection of a bigger trend; a migrant exclusive safety-net system. Migrants have long had insufficient legal access to low-income safety-net systems and continue to have insufficient access now.

Research has shown that social welfare programs help to reduce hardship, increase family stability, and contribute to better health and nutrition for children. (17) Given the vulnerability of migrants, especially during the pandemic, it is even more critical to ensure that they have access to these programs. Migrants in the U.S. are more likely to live in communities with higher infection and death rates from the virus, are disproportionately represented in frontline and essential critical infrastructure, have experienced greater rates of unemployment, are more likely to be uninsured, and more likely to live in crowded homes where isolation of sick family members is oftentimes not possible. (3) Not addressing the needs of a group that makes up such a great percentage of the population during the crisis is simply not addressing the crisis.

Given the influence of migrants in the U.S., successful recovery depends on the adoption of inclusive, uniform policies that encourage health seeking behavior and promote the well-being and livelihood of all, not policies that provoke fear and confusion. The recognition of all people’s right to health is fundamental to the recovery from this global pandemic, and migrant’s access to health and welfare benefits are an integral component to the realization of that right.

8 Limitations

One reviewer was responsible for this study, so although the review was consistent to the study protocol and methodology, it could have been limited by reviewer bias. Additionally, having one person complete the review meant that not as many policies were able to be included. Limiting the scope of the review to legal access also ignored other factors impacting access to services: i.e., language, fear of deportation, and social and cultural barriers. An in-depth analysis of those factors could have provided a more comprehensive understanding of the challenges migrants have to access healthcare.

The inclusion/exclusion criteria are another factor that could have limited the scope of the study. The criteria established were chosen based on time, but the strictness of the criteria may have removed policies undoubtedly affecting migrants, although not directly addressing them. The review would have been richer if other policies potentially affecting migrants (such as proclamations, memorandums, and executive orders) at local, state, and federal levels were included as well. Finally, the study covered policy but not cohesiveness consistency, which means that while two different regulations may not contradict each other it is uncertain if when combine they still leave significant regulatory gaps.

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Annexes

Annex 1: State-Funded SSI Replacement Programs (33)	
This table lists the state-funded programs that provide cash assistance to immigrants who are not eligible for coverage under the federal Supplemental Security Income (SSI) program.	
California	"Qualified" immigrants, PRUCOLs, victims of trafficking, U visa/interim relief applicants, and U visa holders who are ineligible for federal SSI. Benefit levels for individuals are $10 less than the federal SSI and state SSI supplement. Eligibility for this program may be affected by deeming.
Hawaii	"Qualified" immigrant seniors and persons with disabilities can receive Aid to the Aged, Blind and Disabled (AABD), which provides $418 per month.
Illinois	"Qualified" immigrants who were lawfully residing in the U.S. before Aug. 22, 1996, were not receiving SSI on that date, are 65 or older, and are determined ineligible for SSI because they do not have a disability. Eligibility for this program may be affected by deeming. Refugees, persons granted asylum or withholding of deportation/removal, Cuban and Haitian entrants, and Amerasian immigrants, who would be eligible for SSI, but for the expiration of the seven-year eligibility period, can receive up to $500 per month under Illinois' Aid to the Aged, Blind, and Disabled Program.
Maine	"Qualified" immigrants and PRUCOLs who are ineligible for federal SSI. Benefit levels for individuals are equal to the federal SSI and state SSI supplement.
New Hampshire	"Qualified" immigrants who entered the U.S. on or before Aug. 22, 1996, and those who entered after Aug. 22, 1996, who have been in "qualified" immigrant status for 5 years. Refugees, asylees, Cuban/Haitian entrants, Amerasian immigrants and persons granted withholding of deportation/removal are eligible without regard to their date of entry into the U.S.

Annex 2: States Providing Food Assistance to Some Qualified Immigrants Not Eligible for SNAP (34)

This table lists the state-funded programs that provide nutrition assistance to immigrants who are not eligible for coverage under the federally funded Supplemental Nutrition Assistance Program (SNAP), formerly known as the Food Stamp Program.	
California	"Qualified" immigrants, lawful temporary residents, victims of trafficking, U visa/interim relief applicants, and U visa holders. Eligibility for this program may be affected by deeming.
Connecticut	Immigrants ineligible for federal food stamps (SNAP) due to the 1996 federal welfare law eligible for food assistance at 75% of the federal amount. Immigrants who entered the U.S. on or after Apr. 1, 1998, must meet a 6-month residency requirement.
Illinois	Individuals and derivative family members who have filed or are preparing to file an application for T or U status or asylum; terminates if have not filed application within one year (with limited exceptions) or if application finally denied.
Maine	Immigrants ineligible for federal food stamps (SNAP) due to the 1996 federal welfare law and PRUCOLs. Individuals applying after July 1, 2011, must meet hardship criteria in order to qualify. This includes exceptions for seniors, people with disabilities, survivors of domestic violence, people waiting for work authorization, and those granted work authorization who are seeking employment.
Minnesota	Lawfully residing immigrants who are either 50 years or older or are receiving TANF. (The TANF program combines cash and food assistance.) Must take steps toward citizenship. Eligibility for this program may be affected by deeming
Washington	"Qualified" immigrants, PRUCOLs, and lawfully present immigrants. Eligibility for this program may be affected by deeming. Effective February 1, 2022, survivors of trafficking or other serious crimes and asylum applicants who have filed or are preparing to file applications for T or U status, ORR certification, or asylum.

Annex 3: State-Funded TANF Replacement Programs (35)
This table lists the state-funded programs that provide cash assistance to immigrants who are not eligible for coverage under the federally funded Temporary Assistance for Needy Families (TANF) program.

California	**California Work Opportunity and Responsibility to Kids Program (CalWORKs)** “Qualified” immigrants, PRUCOLs, victims of trafficking, U visa relief applicants, and U visa holders. Eligibility for this program may be affected by deeming.
Connecticut	**Temporary Family Assistance** “Qualified” immigrants who have resided in the U.S. for less than five years. Must pursue citizenship unless the immigrant has a medical condition or language barriers, is a victim of domestic violence or is a person with mental retardation. Eligibility for this program may be affected by deeming.
Georgia	**Temporary Assistance for Needy Families (TANF)** “Qualified” immigrants, regardless of their date of entry into the U.S.
Hawaii	**Temporary Assistance for Needy Families (TANF**) “Qualified” immigrants and noncitizens entering the U.S. under the Compact of Free Association (COFA).
Illinois	**Temporary Assistance for Needy Families (TANF)** “Qualified” abused immigrants, regardless of their date of entry into the United States. Effective Jan. 1, 2018, individuals and derivative family members who have filed or are preparing to file an application for T or U status or asylum; terminates if have not filed application within one year (with limited exceptions) or if application finally denied.
Iowa	**Family Investment Program** Abused immigrants who are: (1) lawful permanent residents or conditional permanent residents, (2) asylum applicants, or (3) have approved or pending visa petitions that set forth a prima facie case for relief under the Violence Against Women Act, or an I-130 visa petition filed by a spouse or parent, are eligible regardless of their date of entry into the U.S. Parents and children of abused immigrants also are eligible.
Maine	**Temporary Assistance for Needy Families and Parents as Scholars** “Qualified” immigrants and PRUCOLs. Eligibility for this program may be affected by deeming. Individuals applying after July 1, 2011, must meet hardship criteria in order to qualify, which shall include exceptions for seniors, persons with disabilities, survivors of domestic violence, individuals who are waiting for employment authorization, and individuals granted work authorization who are seeking employment.
Maryland	**Family Investment Program (FIP)** (cash assistance component of FIP is called Temporary Cash Assistance (TCA)) “Qualified” immigrants and lawfully present immigrants. Eligibility for this program may be affected by deeming.
Minnesota	**Minnesota Family Investment Program** Lawfully residing immigrants. If lawful permanent resident (LPR) age 18 through 69, and have been in the country for 4 or more years, and are not residing in a nursing home or similar facility, must (1) enroll in literacy, ESL or citizenship class, or (2) apply for literacy or ESL class, or (3) be in the process of applying for a waiver from the English language or civics requirement of the

	citizenship test, or (4) have submitted a citizenship application, or (5) have been denied citizenship due to a failure to pass the test after 2 or more attempts or because of an inability to understand the rights and responsibilities of becoming a U.S. citizen. Eligibility for this program may be affected by deeming. Family Stabilization Services, a case-management alternative to address barriers to work, is available to lawfully residing immigrants who have been in the U.S. for less than 12 months.
Nevada	**Temporary Assistance for Needy Families** "Qualified" abused immigrants.
New Jersey	**Work First New Jersey** "Qualified" abused immigrants. PRUCOLs who resided in the U.S. prior to Aug. 22, 1996.
New Mexico	**New Mexico Works** "Qualified" immigrants receive state-funded TANF during the five-year bar. Eligibility for this program may be affected by deeming.
New York	**Safety Net Assistance** "Qualified" immigrants who are subject to the five-year bar and PRUCOLs receive assistance through the "Safety Net Assistance" program.
Ohio	**Ohio Works First** Persons under an order of supervision. NOTE: Ohio denies TANF to most "qualified" immigrants who entered the U.S. on or after Aug. 22, 1996, even after they complete the federal 5-year bar.
Oregon	**Aid to Dependent Children (ADC)** "Qualified" immigrants. Victims of domestic violence are eligible, regardless of their immigration status. Eligibility for this program may be affected by deeming.
Pennsylvania	**Temporary Assistance for Needy Families (TANF)** "Qualified" immigrants and PRUCOLs. Eligibility for this program may be affected by deeming.
Rhode Island	**Temporary Assistance for Needy Families (TANF)** "Qualified" abused immigrants.
Tennessee	**Families First** Qualified abused immigrants.
Utah	**Family Employment Program** "Qualified" immigrants. Eligibility for this program may be affected by deeming.
Washington	**WorkFirst** Lawfully present immigrants. Eligibility for this program may be affected by deeming. Effective Feb. 1, 2022, survivors of trafficking or other serious crimes and asylum applicants who have filed or are preparing to file applications for T or U status, ORR certification, or asylum
Wisconsin	**Wisconsin Works (W-2)** "Qualified" immigrants. Eligibility for this program may be affected by deeming. Note: Eligibility for the family is based on the parent's status

Wyoming	**Personal Opportunities with Employment Responsibilities (POWER)** "Qualified" immigrants. Eligibility for this program may be affected by deeming.

Annex 4: Medical Assistance Programs for Immigrants in Various States (36)	
This table describes state policies for providing health coverage to additional groups of immigrants, under federal options to cover lawfully residing children and pregnant women, regardless of their date of entry into the U.S., or to provide prenatal care to women regardless of status, using CHIP funds.	
Alaska	"Qualified immigrants" and PRUCOLs can receive chronic and acute medical assistance if they have a terminal illness, cancer, diabetes, seizure disorders, mental illness, hypertension, or certain other medical conditions.
Arkansas	Lawfully residing children and pregnant women. Prenatal care is available regardless of immigration status
California	"Qualified" immigrants, PRUCOLs, survivors of trafficking, U visa applicants, and U visa– holders. Lawfully residing children and pregnant women. Prenatal care,2 long-term care, breast and cervical cancer treatment, and certain other medical services are available regardless of immigration status. Children and youth under age 26, regardless of immigration status.
Colorado	Lawfully residing children and pregnant women. Lawfully residing immigrants who are ineligible for Medicaid, are over age 60, and are enrolled in the Old Age Pension Program (OAP) may be eligible for medical services (excluding long-term care, psychiatric services, and in-patient hospitalization) through the Old Age Pension Health and Medical Fund. Since January 2014, however, this program has imposed a five-year (or longer) waiting period for new immigrants. Lawfully residing immigrants under 250% FPL may be eligible for the Colorado Indigent Care Program (CICP), regardless of their date of entry into the U.S. CICP is a reimbursement mechanism for hospitals and primary care clinics.
Connecticut	Lawfully residing children and pregnant women. Residents of nursing homes and persons receiving the Connecticut home care program for elders as of June 30, 2011, or who applied for these benefits on or prior to June 1, 2011.
Delaware	Lawfully residing children and pregnant women
District of Columbia	Adults, regardless of immigration status, may be eligible for health coverage through the DC Health Care Alliance. Children, regardless of immigration status,

	may be eligible for the Immigrant Children's Program (ICP), if ineligible for Medicaid.
Florida	Children who do not meet the immigration status criteria for Medicaid or CHIP, but are otherwise eligible, can buy coverage at full cost under KidCare. Lawfully residing children
Hawaii	Lawfully residing children and pregnant women, including residents of Freely Associated States (Marshall Islands, Micronesia, and Palau).1 Seniors and people with disabilities who are qualified immigrants, parolees, and nonimmigrants (including residents of Freely Associated States) receive coverage equivalent to Medicaid. Other lawfully present individuals under 100% FPL will receive state premium assistance in addition to federal subsidies under the health care marketplace created by the Affordable Care Act
Illinois	All children under 300% FPL, regardless of immigration status, can get coverage through the All Kids program. Co-pays and premiums are required for certain families, based on their income. Adults age 65 or older whose income is at or below 100% FPL will be eligible for medical assistance, regardless of their immigration status. "Qualified" abused immigrant adults are also eligible for coverage, regardless of their date of entry. Asylum applicants and torture victims can get up to 24 months of continuous coverage (this period can be extended to 36 months for some asylum applicants). Prenatal care is available regardless of immigration status.2 Noncitizens with end-stage renal disease who receive emergency renal dialysis and meet state residency and other program rules may receive a kidney transplant, regardless of immigration status. Individuals and derivative family members who have filed or are preparing to file an application for T or U status or asylum; terminates if have not filed application within one year (with limited exceptions) or if application finally denied.
Iowa	Lawfully residing children
Kentucky	Lawfully residing children
Louisiana	Prenatal care is available regardless of immigration status.
Maine	Lawfully residing children and pregnant women.
Maryland	Lawfully residing children and pregnant women.1 Limited coverage is available to low and moderate-income Montgomery County residents, regardless of

	immigration status, and to children in families earning up to 250% FPL, regardless of immigration status, in Prince George's County.
Massachusetts	"Qualified," lawfully present, or PRUCOL seniors and persons with disabilities up to 100% FPL (excludes long-term care). "Qualified," lawfully present, or PRUCOL immigrant children under 19 years old are eligible up to 300% FPL; 19- and 20-year-olds are eligible up to 150% FPL.1 All children, regardless of immigration status or income, are eligible for primary and preventive care through the Children's Medical Security Plan. Full-scope medical services for pregnant women up to 200% FPL, regardless of their immigration status. Lawfully present nonpregnant adults are eligible for ConnectorCare; those under 300% FPL who purchase coverage through the ACA Marketplace and receive federal subsidies may qualify for additional state subsidies and cost-sharing equivalent to the levels that were available under Commonwealth Care. Other adults who are PRUCOL but not on HHS's lawfully present list are eligible for MassHealth benefits (excluding long-term care) with the same premium contributions required for ConnectorCare.
Michigan	Prenatal care is available regardless of immigration status.
Minnesota	Lawfully residing children. Prenatal care is available regardless of immigration status. Individuals who receive services from the Center for Victims of Torture. Individuals granted deferred action under the Deferred Action for Childhood Arrivals Program (DACA). Other lawfully present noncitizens under 200% FPL who are ineligible for Medicaid based on their status, are not Medicare recipients, and don't have access to other affordable coverage can receive more limited coverage through MinnesotaCare (excludes, e.g., home-based services, such as personal care assistance and home nursing services).
Missouri	Prenatal care is available regardless of immigration status
Montana	Lawfully residing children
Nebraska	Lawfully residing children and pregnant women. Prenatal care is available regardless of immigration status.
Nevada	Lawfully residing children
New Jersey	Lawfully residing children and pregnant women. Parents who have been lawful permanent residents for less than 5 years and were enrolled in NJ FamilyCare on April 1, 2010, may continue receiving coverage only, in the agency's discretion, if

	being treated for a life-threatening illness or receiving ongoing life-sustaining treatment. NJ FamilyCare Advantage is available to children with family income exceeding 350% FPL, regardless of immigration status, based on payment of premium contribution ("buyin"). Limited funds for prenatal services are available to women up to 200% FPL, regardless of immigration status. "Qualified" immigrants and PRUCOLs who were in Medicaid-certified nursing homes prior to Jan. 29, 1997, remain eligible for nursing home care.
New Mexico	Lawfully residing children and pregnant women and "qualified" battered immigrants. PRUCOLs who entered the U.S. before Aug. 22, 1996.
New York	"Qualified" immigrants and PRUCOLs. Lawfully residing children and pregnant women. Prenatal care is available regardless of immigration status. All children, regardless of immigration status, are covered under the state Child Health Plus program.
North Carolina	Lawfully residing children and pregnant women.
Ohio	Lawfully residing children and pregnant women.1 People who were lawfully residing in the U.S. on Aug. 22, 1996, and some individuals under an order of supervision.
Oklahoma	Prenatal care is available regardless of immigration status, under Soon to be Sooners program.
Oregon	Lawfully present children.1 Prenatal care is available regardless of immigration status. Children regardless of immigration status. COFA Premium Assistance Program for residents of Freely Associated States (Marshall Islands, Micronesia, and Palau) earning under 138% FPL who enroll in a qualified health plan.
Pennsylvania	Lawfully residing children and pregnant women.1 State-funded Medical Assistance is available to lawfully residing immigrants who are otherwise eligible.
Rhode Island	Lawfully residing children. Prenatal care is available regardless of immigration status. Lawfully residing persons who were in the U.S. before Aug. 22, 1996, and were residents of Rhode Island before July 1, 1997, are also covered.
South Carolina	Lawfully residing children and pregnant women.
Tennessee	Prenatal care is available regardless of immigration status, under CoverKids (Healthy TN Babies).

Texas	Lawfully residing children who entered the U.S. on or after Aug. 22, 1996, are eligible for children's Medicaid or CHIP, depending on their income. Prenatal care is available regardless of immigration status through the CHIP Perinatal program. NOTE: Texas denies federal Medicaid to most "qualified" immigrant adults who entered the country on or after Aug. 22, 1996, even after they complete the federal 5-year bar.
Utah	Lawfully residing children.
Vermont	Lawfully residing children and pregnant women.
Virginia	Lawfully residing children and pregnant women
Washington	Seniors and persons who are blind or have disabilities, and who are lawfully present may be eligible for a limited medical care services program. Prenatal care is available to otherwise-eligible women regardless of immigration status. Children in households with income below 215% FPL are eligible for medical coverage without a share of cost, regardless of their immigration status. Monthly premiums are required for children in families earning between 215% and 317% FPL. Effective Feb. 1, 2022, survivors of trafficking or other serious crimes and asylum applicants who have filed or are preparing to file applications for T or U status, ORR certification, or asylum will be eligible for medical assistance.
West Virginia	Lawfully residing children and pregnant women.
Wisconsin	Lawfully residing children and pregnant women. Prenatal care is available regardless of immigration status.
Wyoming	Lawfully residing pregnant women. NOTE: Wyoming denies Medicaid to most nonpregnant lawful permanent residents who do not have credit for 40 quarters of work history in the U.S.

Annex 5: Medicaid and CHIP Coverage of Lawfully Residing Children & Pregnant Women (37)
This table describes the states using the option to provide Medicaid and CHIP coverage to children and pregnant women who are lawfully residing in the United States, including those within their first five years of having certain legal status. This coverage may be applied to pregnant women in Medicaid and

CHIP and/or to children up to age 19 for CHIP or up to age 21 for Medicaid who would otherwise be eligible for coverage through these programs.	
Arkansas	CHIP (children), Medicaid (children and pregnant women)
California	CHIP (children), Medicaid (children and pregnant women)
Colorado	CHIP (children and pregnant women), Medicaid (children and pregnant women)
Connecticut	CHIP (children), Medicaid (children and pregnant women)
Delaware	CHIP, Medicaid (children and pregnant women)
District of Columbia	CHIP, Medicaid (children and pregnant women)
Florida	CHIP (children), Medicaid (children)
Hawaii	CHIP, Medicaid (children and pregnant women)
Illinois	CHIP (children), Medicaid (children)
Iowa	CHIP (children), Medicaid (children)
Kentucky	CHIP (children), Medicaid (children)
Louisiana	CHIP (children), Medicaid (children)
Maine	CHIP (children), Medicaid (children and pregnant women)
Maryland	CHIP, Medicaid (children and pregnant women)
Massachusetts	CHIP (children), Medicaid (children and pregnant women)
Minnesota	CHIP (children), Medicaid (children and pregnant women)
Montana	CHIP (children), Medicaid (children)
Nebraska	CHIP (children), Medicaid (children and pregnant women)
Nevada	CHIP (children), Medicaid (children)
New Jersey	CHIP (children and pregnant women), Medicaid (children and pregnant women)
New Mexico	CHIP, Medicaid (children and pregnant women)

New York	CHIP (children), Medicaid (children and pregnant women)
North Carolina	CHIP (children), Medicaid (children and pregnant women)
Ohio	CHIP, Medicaid (children and pregnant women)
Oregon	CHIP (children), Medicaid (children)
Pennsylvania	CHIP (children), Medicaid (children and pregnant women)
Rhode Island	CHIP (children), Medicaid (children)
South Carolina	CHIP, Medicaid (children and pregnant women)
Texas	CHIP (children), Medicaid (children)
Utah	CHIP (children), Medicaid (children)
Vermont	CHIP, Medicaid (children and pregnant women)
Virginia	CHIP (pregnant women and children), Medicaid (children and pregnant women)
Washington	CHIP (children), Medicaid (children and pregnant women)
West Virginia	CHIP (children and pregnant women), Medicaid (children and pregnant women)
Wisconsin	CHIP (children), Medicaid (children and pregnant women)
Wyoming	CHIP, Medicaid (pregnant women)