

## APPENDIX I

# MAJOR LEGISLATIVE MILESTONES IN US IMMIGRATION HISTORY

### CHINESE EXCLUSION ACT OF 1882

- Suspends immigration of Chinese laborers for ten years.
- Bars Chinese naturalization.
- Provides for the deportation of Chinese illegally in the United States.

### IMMIGRATION ACT OF 1891

- First comprehensive law for national control of immigration.
- Establishes Bureau of Immigration under Treasury.
- Directs deportation of aliens unlawfully in country.

### IMMIGRATION AND NATURALIZATION ACT OF 1924

- Imposes first permanent numerical limit on immigration.
- Establishes the national origins quota system, which resulted in biased admissions favoring northern and western Europeans.

### IMMIGRATION AND NATURALIZATION ACT OF JUNE 27, 1952

- Continues national origins quotas.
- Establishes quota for skilled aliens whose services are urgently needed.

### IMMIGRATION AND NATIONALITY ACT AMENDMENTS OF OCTOBER 3, 1965

- Repeals national origins quotas.
- Establishes seven-category preference system based on family unification and skills.
- Sets 20,000 per country limit for immigration from the Eastern Hemisphere.
- Imposes ceiling on immigration from Western Hemisphere for first time.

### IMMIGRATION AND NATIONALITY ACT AMENDMENTS OF 1976

- Extends 20,000 per country limits to immigration from the Western Hemisphere.

### REFUGEE ACT OF 1980

- Sets up first permanent and systematic procedure for admitting refugees.
- Removes refugees as a category from preference system.
- Defines refugee according to international, versus ideological, standards.
- Establishes process of domestic resettlement.
- Codifies asylum status.

### IMMIGRATION REFORM AND CONTROL ACT OF 1986

- Institutes employer sanctions for knowingly hiring illegal aliens.
- Creates legalization programs.
- Increases border enforcement.
- Creates \$4 Billion State Legalization Impact Assistance Grant Program.

### IMMIGRATION ACT OF 1990

- Increases legal immigration ceilings by 40 percent and triples employment-based immigration.
- Creates diversity admissions category.
- Establishes temporary protected status for those in the United States jeopardized by armed conflict or natural disasters in their native countries.

### ILLEGAL IMMIGRATION REFORM AND IMMIGRANT RESPONSIBILITY ACT OF 1996

- Increases penalties for alien smuggling and document fraud.
- Provides for expedited removal of inadmissible aliens.
- Bars unlawfully present immigrants from re-entry for longer periods of time.
- Sets income requirements for immigrant sponsors at 125 percent of federal poverty level.

This chart has been updated since its original publication in *Setting the Record Straight*, by M. E. Fix and J. S. Passel (Washington, DC: The Urban Institute, 1994). It is reprinted here with permission from The Urban Institute.

## APPENDIX II

# ACCESS TO HEALTH CARE AFTER IMMIGRATION REFORM: LESSONS FROM NEW YORK

ADAM GURVITCH

Immigration reform could affect millions of American workers, public and private health care providers, insurers, and public health. Among other things, reform could create new categories of temporary workers, increase the number of lawful permanent residents, and change the treatment of unauthorized residents. This appendix focuses on access to health care and presents the author's practical considerations for policymakers who must plan for the consequences of reforms at state and local levels. Examples from the state of New York are used to illustrate how options for immigrants' health care access might be implemented.

## GUIDING PRINCIPLES

Whatever approach is chosen to provide health care access for participants in an immigration reform program, the following principles should guide reform:

- Do not add to the ranks of the uninsured.
- Favor the simplest, least costly administrative structures.
- Consider the interests of both healthy individuals and those who have medical needs.
- Do not weaken employer-based health insurance coverage.
- Strengthen the health care safety net for everyone in the community.

## KEY DESIGN ELEMENTS

In thinking about how to structure access to health care at the local level for temporary workers and other individuals who participate in an immigration reform program, the following considerations are important:

### STAKEHOLDER INVESTMENT

Employer and employee assessments or contributions are assumed to be the primary source of funding for access to health care when discussing policy options. Immigration reform that is designed to benefit employers and workers should come with the expectation that each will contribute to ensuring adequate access to health care. Employers that provide health insurance benefits to workers who benefit from immigration reform could be granted an offset or credit against the employer's assessed cost of participating in the immigration program (payment of fees, for example).

### FAIRNESS IN TAXATION

Workers who reside in the United States and pay federal income taxes should be able to obtain federal means-tested public benefits on the same basis as any other American if they fall on hard times. This basic fairness is especially relevant when faced with urgently needed, expensive medical care.<sup>1</sup>

### ACCESS TO EMERGENCY CARE

Emergency medical transportation and emergency health care are generally extended to all persons in the United States experiencing an emergency medical condition, upholding our long-standing respect for basic human decency; immigration reform should retain this commitment to all US residents.<sup>2</sup>

### STOP-LOSS PROTECTION FOR CATASTROPHIC CARE

Medical care is extremely expensive for the vast majority of Americans and is distinct in nature from other types of expenses and debts because medical care is often incurred involuntarily. US citizens gain access to Medicaid if they have limited income and exhaust their disposable resources.<sup>3</sup> Migrants admitted

---

1 For a description of the restrictions currently imposed on legal immigrants' access to Medicaid and the State Children's Health Insurance Program (SCHIP), see the US Department of Health and Human Services, Centers for Medicare and Medicaid Services (CMS) Web site: [http://www.cms.hhs.gov/MedicaidEligibility/05\\_Immigrants.asp#TopOfPage](http://www.cms.hhs.gov/MedicaidEligibility/05_Immigrants.asp#TopOfPage).

2 42 U.S.C. § 1395dd. US Department of Health and Human Services, Centers for Medicare and Medicaid Services (CMS) Emergency Medical Treatment and Labor Act (EMTALA) Web site: <http://www.cms.hhs.gov/EMTALA>.

3 US Department of Health and Human Services, Centers for Medicare and Medicaid Services (CMS) Web site: <http://www.cms.hhs.gov/home/medicaid.asp>. See also, "The Medicaid Program At a Glance" (Washington, DC: Kaiser Commission on Medicaid and the Uninsured, Henry J. Kaiser Family Foundation, 2005), <http://www.kff.org/medicaid/upload/The-Medicaid-Program-at-a-Glance-Fact-Sheet.pdf>.

under immigration reform will need some form of stop-loss protection against catastrophic medical costs; options include Medicaid,<sup>4</sup> Medicare, or restricted scope Medical Assistance for an emergency medical condition (“emergency Medicaid”).<sup>5</sup> This protection will also ensure that safety net health providers are reimbursed, at least in part, for the costs of treating low-income patients.

## RESIDENCY

Participants in immigration reform should be treated at least as favorably as H-1 visa holders for the purposes of participating in programs and services that currently impose a state or local residency requirement. Examples of programs that require proof of residency but not legal status include public health services, federally qualified health centers, hospital reimbursement for the treatment of an emergency medical condition through “emergency Medicaid,” and, in states such as New York, free or subsidized insurance for children, pregnant women, and individuals living with HIV and AIDS.<sup>6</sup>

## PUBLIC NOTICE

The nation’s experience with the recent drug reimbursement or Medicare Part D program clearly demonstrates how important it will be for the government to provide clear instructions about health programs to participants in immigration reform. Clear communications will be vital to addressing concerns and misconceptions that lead many foreign-born individuals to avoid using health programs.<sup>7</sup>

## POLICY OPTIONS

Access to health care is important to workers, employers, and communities alike. Public health is safeguarded only when all members of a community are willing to come forward for screening and treatment in the event of an epidemic or biological or chemical exposure. Employers experience workers’ illness,

---

4 The federal Medicaid program’s medically needy (MN) option allows states to extend Medicaid eligibility to persons whose income and/or resources are above the eligibility level set by their state. Persons may qualify immediately or may “spend down” by incurring medical expenses that reduce their income to or below their state’s MN income level. Thirty-five states have adopted the medically needy option, and the remaining states have Medicaid for people who are “near poor.” More information can be found at: [http://www.cms.hhs.gov/MedicaidGenInfo/03\\_TechnicalSummary.asp#TopOfPage](http://www.cms.hhs.gov/MedicaidGenInfo/03_TechnicalSummary.asp#TopOfPage).

5 J. Perkins, “Medicaid Coverage of Emergency Medical Conditions,” *Clearinghouse Review Journal of Poverty Law and Policy* 384 (Sept/Oct 2004).

6 New York State, Department of Health — Medical Assistance Program: GIS 04 MA/003 Attachment 1, 2004.

7 T. Bauer, J. Bergman, C. Hill, J. Fuld, and L. Weiss, “Access to Health Insurance and Health Care for Children in Immigrant Families” (New York: The New York Academy of Medicine, publication forthcoming).

injury, and disability as lost productivity and increased training and recruitment costs. US residents who cannot afford health care avoid seeking it until faced with an emergency, resulting in a less healthy, less effective population.

This paper presents five alternatives for achieving varying levels of access to health care under immigration reform, with the goals of maintaining a healthy workforce and protecting public health and the financial soundness of the US health care system.

## OPTION ONE: INSURANCE BUY-IN

Individuals who participate in an immigration reform program would be allowed or required to enroll in one of the following existing health coverage programs by paying a group-rated premium: employer-based insurance, state employee health insurance plans, Medicaid, or Medicare.

Under the health insurance buy-in option, both employers and participants in immigration reform would be assessed a fee or would pay a “premium,” with additional contributions required on behalf of any dependents. Employers’ contributions would receive the same favorable federal and state tax treatment currently in place, constituting a government subsidy of health benefits provided by private-sector employers.

An insurance buy-in is an attractive option for providing affordable access to a full range of health services, and can potentially strengthen the public and private insurance systems. Temporary workers and other participants in immigration reform will presumably be required to pass a medical screening prior to obtaining permission from the federal government to reside and work in the United States. By definition, this population will generally be in better health and less likely than US-born citizens to be disabled, chronically and persistently ill, impaired, unable to work, or elderly.<sup>8</sup> It is axiomatic that 20 percent of the population generates 80 percent of all health care expenses in the United States. Adding a large number of healthy individuals to the existing population of an insurance pool would favorably distribute risks and contain the cost of insurance premiums, while promoting solvency.

*New York State’s Child Health Plus program provides an example of a successful insurance buy-in model; the program provides coverage for preventive, primary, and emergency services to any uninsured New York State resident*

---

8 T. Norgren, “Mexicans in New York City: Demographics and Health of the City’s Fastest Growing Hispanic Group” (New York: Medical and Health Research Association of New York City, publication forthcoming).

younger than 19.<sup>9</sup> The program allows families that earn too much to qualify for children's Medicaid to purchase group-rated insurance coverage for uninsured children through the state's Child Health Plus program.

Monthly insurance premiums in the Child Health Plus program vary by family income, with the highest monthly premium set at roughly \$150 for a quality insurance plan with modest co-pays; a level more affordable than health plans with comparable benefits available for the same population through the private insurance market. Enrollment in the program has been high among low- and middle-income families that do not receive health coverage through their employers. The Child Health Plus buy-in program essentially provides universal health coverage to uninsured New Yorkers through age 18, regardless of immigration status. The program consistently receives bi-partisan political support throughout New York state.

While the United States spends more per capita on health care than any other country, many US residents are unable to access care, and for many who do, the financial consequences can be devastating: Medical debt is a leading cause of bankruptcy and homelessness in the United States.<sup>10</sup> Many people who work find it difficult or impossible to receive adequate medical care without health insurance; this is true not only for life-saving treatments but also for the routine management of chronic conditions.

While immigrants are as likely to be employed as native-born citizens, immigrants are three times as likely to lack insurance, and immigrant workers are much less likely than native-born workers to receive health insurance coverage through their employers.<sup>11</sup> Immigrants work the most dangerous jobs, with the fewest workplace protections, for the lowest wages in the labor market.<sup>12</sup> Many immigrant New Yorkers become at-risk for health problems when they enter the workforce; immigrants account for nearly 40 percent of workplace deaths in New York state.<sup>13</sup>

---

9 Information about New York State's Child Health Plus program can be found at the New York City Web site: [http://www.nyc.gov/html/hia/html/public\\_insurance/children.shtml](http://www.nyc.gov/html/hia/html/public_insurance/children.shtml).

10 The Access Project, "Home Sick," 2005, <http://www.accessproject.org/medical.html>.

11 R. Capps, M. Fix, J. Passel, J. Ost, and D. Perez-Lopez, "A Profile of the Low-Wage Immigrant Workforce" (Washington, DC: The Urban Institute, 2003); M. Fix and R. Capps, "Immigrant Well-Being in New York and Los Angeles" (Washington, DC: The Urban Institute, 2002).

12 S. Richardson, "Fatal Work Injuries Among Foreign-Born Hispanic Workers," US Department of Labor, Bureau of Labor Statistics, *Monthly Labor Review* (October 2005), <http://www.bls.gov/opub/mlr/2005/10/ressum.pdf>.

13 According to the US Bureau of Labor Statistics, 39 percent of fatal occupational injuries in New York State in 2000, and 67 percent of fatal occupational injuries in New York City were immigrant workers. See New York State Trial Lawyers Association, "New York's "Scaffold Law": An Essential Protection for Immigrant Construction Workers," 2004.

Most legal immigrants arriving in the United States since August 22, 1996, are categorically barred for five years from receiving federal means-tested public benefits, including the Medicaid and SCHIP health programs.<sup>14</sup> These bars remain in place despite the fact that these individuals — lawful permanent residents — are authorized to work and required to pay taxes that directly subsidize others' health benefits. Immigration reform, whether in the form of a temporary worker program, earned legalization program, or a broad expansion in permanent visas, will achieve greater legitimacy if it corrects the failure of earlier policies that prevent legal immigrants from accessing safety net supports during times of hardship.

Many New Yorkers, including hundreds of thousands of immigrants, earn too much to qualify for public coverage, too little to afford private coverage, and lack affordable coverage through their employers.<sup>15</sup> Any proposal aimed at ensuring access to affordable health care for the participants in immigration reform must also take into account the situation facing other uninsured Americans, including the US-born. That said, foreign-born residents who are permitted to live and work in the United States must have access to affordable health care in order to avoid circumstances of extreme inequity and exploitation.

A basic assumption is that the immigration reform programs will be designed with the rights of all workers in mind and will not undermine working conditions for any segment of the workforce — newly minted or well-established. It is crucial to ensure that employers who already provide health insurance benefits maintain that effort.

## ADVANTAGES OF THE INSURANCE BUY-IN

- The option would subsidize US-born individuals who are insured by adding significantly younger and healthier participants to existing insurance pools.
- It would utilize existing infrastructure and administrative mechanisms and achieve savings through economies of scale.
- Cost-effective preventive and primary care could be accessed, as well as emergency and specialty care. Access to comprehensive care would be possible, depending on the design of the insurance products.

---

14 US Department of Health and Human Services website, "Summary of Immigrant Eligibility Restrictions Under Current Law as of 10/04/2004": <http://aspe.hhs.gov/hsp/immigration/restrictions-sum.htm>.

15 E. Hubert, D. Holahan, and A. Cook, "Health Insurance Coverage in New York, 2002-2003" (New York: United Hospital Fund, 2005).

- Health providers could adapt their existing billing and claims systems, and new administrative and information technology requirements would be minimized.
- Participants could access care through outpatient and clinical settings, rather than relying on much more costly emergency care.
- Health coverage would be portable: Individuals could avoid becoming uninsured if they change jobs or move to a different community.
- The insurance buy-in option would build on programs that work well for people, including individuals who have high needs for health care.
- It would help shore up Medicaid, Medicare, employer-based, and private insurance pools.

## CONCERNS

- Many current US citizens and lawful permanent residents (“green card” holders) are not provided with insurance buy-in options,<sup>16</sup> therefore a tough political case would have to be made as to why employers of these new segments of the workforce are held to higher standards for subsidizing their employees’ health benefits.
- A significant proportion of immigrants have difficulty navigating managed care, and they consequently under-utilize health care that is delivered in this way.<sup>17</sup>

## OPTION TWO: SAFETY NET “MEDICAL HOME”

Participants in immigration reform programs who do not receive insurance through their employers would be matched with safety net health care providers, and a paying relationship would be established according to the providers’ prevailing fees for uninsured patients. Participants would be encouraged or required to obtain a clinic card and receive an initial health screening.

---

16 A. Safir and H. Leibovitz, “State Profile of New York - Data from the 2002 National Survey of America’s Families” (Washington, DC: The Urban Institute, 2004).

17 New York Community Service Society, “Low Income Consumers’ Experiences: Results from a Citywide Survey of Managed Care Consumers in Medicaid, Child Health Plus, and Family Health Plus,” 2005.

The safety net provider would help to enroll participants into any public insurance programs for which the immigrant qualifies, and those who did not obtain coverage would be charged on the same discounted basis as any other current member of the community, including US citizens and lawful permanent residents.<sup>18</sup> A mechanism would be established to bring employers into the finance system.

*New York City's Health and Hospitals Corporation (HHC, the public health care system) represents a model for providing insurance screening and financial assistance based on patients' income, regardless of immigration status. The HHC Options program enables current and prospective patients who are uninsured to establish fee reductions from health safety net providers and to have pharmacies reduce or waive the cost of medications.<sup>19</sup> The program enables New Yorkers to access care in the most cost-effective clinical settings, rather than delaying care out of fear of financial consequences and then relying on much more costly emergency care. HHC finds that its generous financial assistance program provides an incentive for patients to cooperate with the hospital's financial counselors, which enables the hospital system to optimize patients' enrollment in insurance programs and maximize reimbursements to the hospital.*

Federally qualified community health centers (FQHCs), FQHC look-alikes, rural and migrant health centers, and public and private hospitals and clinics comprise a health care safety net in the communities where participants in immigration reform are likely to be concentrated.<sup>20</sup> The Bush Administration has expressed a strong commitment to increasing funding for FQHCs and to ensuring that one is open in most counties.

The immigration reform population (guest workers, legalizing immigrants, e.g.) would not have special rights, just the same rights all others currently share.

The rationale for putting uninsured participants into contact with safety net health care providers is the strong desirability of establishing a “medical home.”<sup>21</sup> Making the match with a safety net provider and establishing a “med-

---

18 Participants in an immigration reform program who meet some definition of “high-income,” and whose employers do not provide health benefits, could be mandated to purchase private insurance or buy-in to group coverage as a condition of residing in the United States.

19 New York City Health and Hospitals Corporation — HHC Options Web site: [http://www.nyc.gov/html/hhc/html/community/hhc\\_options.shtml](http://www.nyc.gov/html/hhc/html/community/hhc_options.shtml).

20 US Department of Health and Human Services, Centers for Medicare and Medicaid Services (CMS) FQHC Web site: <http://www.cms.hhs.gov/center/fqhc.asp>.

21 For a description of the concept of “medical home,” see the American Academy of Pediatrics Web site: <http://www.medicalhomeinfo.org>.

ical home” would ensure that uninsured participants would not be deterred from seeking needed medical care due to fear of devastating medical debt or immigration-related concerns. Currently, too few immigrants in New York City understand the options for affordable care available through the health care safety net, and they delay care until their conditions become serious, resulting in poorer health and more costly care down the line.<sup>22</sup>

The health care safety net is already burdened by the uncompensated and under-compensated care it provides — a burden that is partially explained by the system’s failure to proactively undertake patient education and outreach about the availability of reduced-cost care, outpatient services, and public coverage.<sup>23</sup> Uninsured US residents, and immigrants in particular, often receive the full bill for services, when in actuality there are reductions that could be applied, or coverage for which people are eligible but not enrolled. This confusion results in large numbers of uninsured residents who are unable or afraid to seek health care.

## ADVANTAGES OF THE SAFETY NET “MEDICAL HOME”

- Establishing a “medical home” would greatly increase the likelihood that health care would be obtained in a timely and cost-effective way through preventive and primary care.
- Health providers could adapt their existing billing and claims systems.
- Participants could obtain care through outpatient and clinical settings, rather than relying on much more costly emergency care.
- This option would make it more likely that participants could receive culturally competent, linguistically accessible services regardless of their ability to pay, and further, that low-cost payment options would be available, such as sliding-scale fee reductions.
- It would provide access to comprehensive care in most regions in the United States.

---

22 M. Doty, J. Edwards, and A. Holmgren, “Seeing Red: Americans Driven into Debt by Medical Bills” (New York: The Commonwealth Fund, 2005).

23 E. Benjamin et al., “State Secret: How Government Fails to Ensure that Uninsured and Underinsured Patients Have Access to State Charity Care Funds” (New York: The Legal Aid Society — Health Law Unit, 2004). See also, “Hospital Free Care: Can New Yorkers Access Hospital Services Paid for by Our Tax Dollars?” (New York: Public Policy and Education Fund of New York, 2003).

- It would strategically utilize existing capacity in the health care system.

## CONCERNS

- This option would require matching individuals with medical providers directly, which could involve additional administrative complexity and resources.
- FQHCs and rural and migrant health centers provide preventive and primary care services, but may not provide vision or dental care, and generally do not provide emergency or acute care. However, in many areas of the United States these clinics are the only available source of care to uninsured individuals. Some form of wrap-around coverage might be necessary to reimburse providers for catastrophic health care expenses; the federal government’s “emergency Medicaid” program currently serves this function.
- Patients’ advocates distrust proposals that appear to channel individuals into the public health care system, fearing a two-tiered system. However, the reality for most uninsured US residents is that private health care is unaffordable and inaccessible. This population ultimately ends up receiving care from public providers, if it receives care at all. Assignment to a “medical home” would not preclude the participation of private providers or limit participants’ freedom to seek care.
- It would lack portability — an individual who relocated would need to be financially screened again and establish a relationship with a new provider.
- The health care safety net in many areas of the country is over-burdened and could ill afford to take on large additional numbers of uninsured patients.<sup>24</sup>

## OPTION THREE: PRE-PAID MEDICAL CARE

Option Three would be the same as Option Two, with the addition of an annual assessment — for instance \$500 to \$1,000 — paid into a pool by employers and workers. The pool could allocate this money to the local FQHC or other comparable safety net health care provider. As above, participants would make contact with their “medical home” — an outpatient clinic — and receive a

---

<sup>24</sup> The reimbursement rates that hospitals and clinics receive from Medicaid and Medicare for providing many outpatient services have lagged behind medical inflation for decades, resulting in fundamental structural deficiencies.

medical exam and needed care. Payment would occur either by redeeming a coupon or through a pre-paid clinic card provided to participants in an immigration reform program.

The medical fees would be determined on a sliding-scale basis, as is currently the case for any other low- or moderate-income patient, and the provider would draw down from the pre-paid assessment. If a participant required more care during the period than the pre-paid assessment covered, he or she could then pay the provider's prevailing sliding-scale charges out of pocket, like anyone else. If, at the end of the year, the participant had not utilized care in the amount of the pre-paid assessment, the remainder could revert to the safety net provider or be rolled over into a future period.

Pre-paid medical care would not constitute insurance coverage; instead it would establish a financial relationship directly between the patient and the health provider. Under this option, the individual would be asked to pay a sliding-scale rate to the health provider for any medical care used in excess of the pre-paid amount. This option would allow decisions about what medical care was needed to be made by health care providers, rather than by managed care administrators, whose profit motives and duties to shareholders can be at odds with the fundamental aim of providing appropriate medical care to patients.

In addition to the advantages and concerns set out under Option Two, "Safety Net Medical Home," this option would require making direct transfers of employee and employer assessments to medical providers, which would involve additional administrative complexity.

#### OPTION FOUR: NEWLY CREATED INSURANCE PROGRAM

With government assistance, small businesses and other employers that do not currently provide employee health benefits could join together to form newly created health insurance programs for pooled employees. Participants in an immigration reform program could be encouraged or required to enroll, and group-rated premiums would be paid by assessments or contributions from employees and employers. These new insurance products could also be opened up to other uninsured US residents, including workers who are classified by employers as temporary, contingent, or part-time employees, who do not receive prevailing benefits, and who cannot afford to pay out-of-pocket for healthcare.

*New York State offers small employers, sole proprietors, and uninsured working individuals the opportunity to purchase health insurance coverage through*

*the Healthy NY program. These health benefits are made more affordable through state subsidies. Healthy NY includes inpatient and outpatient hospital services, physician services, maternity care, preventative health services, diagnostic and X-ray services, and emergency services. Participants may choose a benefit package with a limited prescription drug benefit or a benefit package without a prescription drug benefit.<sup>25</sup> Participation in Healthy NY has lagged behind expectations, largely due to the high cost of the program's premiums.*

The success of a newly created insurance program would depend on its ability to offer affordable group-rated premiums and a competitive benefits package. Such a program would be unlikely to attract many participants if it presented only small reductions in cost compared to individual insurance coverage on the private market, which is currently well out of reach for many US residents. However, very significant reductions in cost could be achieved if the government permitted small businesses, sole proprietors, and others to pool their employees and to purchase group-rated insurance. These pools would essentially replicate the conditions that have enabled large employers to successfully provide employee health benefits. This approach to creating a new insurance program would share many advantages and concerns with Option One, "New Insurance Buy-In."

## OPTION FIVE: ANNUAL MEDICAL SCREENING

Temporary workers and other participants in an immigration reform program would receive an initial health screening and periodic screenings thereafter from a safety net health care provider such as a hospital, FQHC, FQHC look-alike, rural or migrant health clinic, or private provider that wishes to participate. Assuming that immigration reform will contain some sort of required screening for transmissible diseases, this could be accomplished along with a thorough check-up.

*New York State's Bureau of Refugee and Immigrant Affairs subsidizes medical screenings for newly arrived refugees in the communities where they are resettled.<sup>26</sup> Through the Refugee Health Screening program, refugees receive free medical screening for contagious diseases during their first few months in the country from designated clinics. The limitation of this screening program is that if health conditions other than contagious diseases are detected there is*

---

<sup>25</sup> New York State — Healthy NY Web site: <http://www.ins.state.ny.us/website2/hny/english/hny.htm>.

<sup>26</sup> New York State, Office of Temporary and Disability Assistance, Bureau of Refugee and Immigrant Affairs Web site: [http://www.otda.state.ny.us/otda/bria/bria\\_prog\\_default.htm](http://www.otda.state.ny.us/otda/bria/bria_prog_default.htm).

*no payment system in place and many providers refuse to treat uninsured patients, including those seen through the Refugee Health Screening program.*<sup>27</sup>

The idea behind the medical screening option is to track “fitness to work” and make a linkage to an appropriate, affordable source of health care other than the emergency room.<sup>28</sup> Pre-paid clinic cards or some other payment mechanism would be used. If the individual needed ongoing care, for example to manage a chronic condition such as diabetes or asthma, he or she would work out a sliding-scale fee or payment plan with a safety net provider, like any other patient (as in Option Two).

## ADVANTAGES OF THE ANNUAL MEDICAL SCREENING

- An annual medical screening would assure that participants’ basic health status was monitored.
- This option would establish a link between participants and primary care providers. However, some providers may not be willing to treat patients beyond administering the health screening.
- The screening could be paired with more comprehensive wrap-around health benefits, such as employer-sponsored insurance, buy-in options, or “emergency Medicaid.”
- The government’s Refugee Medical Screening program already exists, and that program’s clinic reimbursement system might provide a model.
- This option would enable public health surveillance and monitoring.

## CONCERNS

- While the screenings could identify problems, this option would not provide for treatment, medication, or follow-up care. The participant would essentially remain uninsured, making this option limited in its usefulness, unless paired with other health access options.

---

27 Refugees are also eligible to enroll for eight months in the government’s Refugee Medical Assistance (RMA) program, which reimburses health providers for services received by participating refugees; however, some refugees themselves may be unaware of this program and, in practice, health providers sometimes fail to assist refugees in applying for the RMA benefits.

28 The Access Project, “Paying for Health Care When You’re Uninsured: How Much Support Does the Safety Net Offer?” 2003.

## ADDRESSING OBSTACLES TO HEALTH CARE

The existing disparity in access to health care faced by immigrants in the United States is striking. Apart from the obvious consequences of being categorically barred from public insurance programs, having low rates of health insurance and low incomes, legal immigrants are confronted with a distinct set of concerns.<sup>29</sup> Immigration laws and policies are continually evolving, and the rules about immigrants' rights to government programs and services have changed significantly in recent years.<sup>30</sup>

The foreign born in the United States under-utilize medical care in part as a result of the chilling effect of government policies aimed at legal immigrants (not those who are unauthorized), including public charge, sponsor liability, and immigration-related restrictions on eligibility for government programs.<sup>31</sup> Legal immigrants receive conflicting messages about their rights to health care and their risks from using programs and services, with different perspectives and sometimes misleading advice being offered by government, lawyers, and health care providers.<sup>32</sup> In this complex information environment where much is at stake, many legal immigrants avoid enrolling in public programs or accessing health care due to a belief that doing so will interfere with their ability to sponsor and reunite with close family members such as spouses, children, and parents who live abroad.<sup>33</sup> For low-income newcomers, the health care system is nearly impossible to navigate without orientation or assistance.

The financial hardship experienced by uninsured and underinsured immigrants who use the health care system feeds negative word-of-mouth and further contributes to under-utilization of health care and reliance on more costly emer-

---

29 Norgren, "Mexicans In New York City" (see n. 8); T. Broder, "Immigrant Eligibility for Public Benefits," in *Immigration and Nationality Law Handbook*, 759 (Washington, DC: American Immigration Lawyers Association, 2005-2006 edition, updated March 2005), <http://www.nilc.org/immspbs/index.htm#immelig>.

30 R. Capps, R. Koralek, K. Lotspeich, M. Fix, P. Holcomb, and J. Reardon-Anderson, "Assessing Implementation of the 2002 Farm Bill's Legal Immigrant Food Stamp Restorations: Final Report to the United States Department of Agriculture Food and Nutrition Science" (Washington, DC: The Urban Institute, 2004).

31 S. Mohanty et al., "Health Care Expenditures of Immigrants: A Nationally Representative Analysis," *American Journal of Public Health* 95, no. 8 (Aug 2005): 1431-1438; Bauer et al., "Access to Health Insurance and Health Care" (see n. 7).

32 An example of misleading information provided by the US government to immigrants was retrieved on February 11, 2006, from the Web site of the US Department of Health and Human Services, Centers for Medicare and Medicaid Services (CMS): "Your child may be eligible for coverage if he or she is a US citizen or a lawfully admitted immigrant, even if you are not (*however, there is a 5-year limit that applies to lawful permanent residents*)." [Emphasis added] There has never been a five-year limit on eligibility.

33 Children's Defense Fund, "Health Insurance in New York City: Is It Working for Immigrant Families?" 2003.

gency room care.<sup>34</sup> Linguistic isolation compounds the challenge.<sup>35</sup> Millions of newcomers are not able to explain their symptoms or understand a medical diagnosis using English. They are also unable to navigate the hospital registration and billing systems and health coverage enrollment processes in English. Government will face a tough challenge to explain the rights and process at all levels for obtaining health care and insurance, or payment options, under immigration reform.

---

34 Bauer et al., "Access to Health Insurance and Health Care" (see n. 7).

35 R. Capps, L. Ku, M. Fix, et al., "How Are Immigrants Faring after Welfare Reform? Preliminary Evidence from Los Angeles and New York City" (Washington, DC: The Urban Institute, 2002).

## APPENDIX III

# NEW AMERICANS: SELECTED FACTS ON NATURALIZATION AND BIRTHRIGHT CITIZENSHIP

MARY HELEN YBARRA JOHNSON,

MICHAEL FIX, AND JULIE MURRAY

## THE CITIZENSHIP TEST CIRCA 2006

The Immigration and Naturalization Act of 1952 requires the testing of individuals seeking US citizenship on English-language ability and knowledge and understanding of US history and government. The current test is given in a principally oral, rather than written, format. Applicants' language skills are evaluated during the course of the oral test on US history and government, to ensure that they have at least an elementary level of English, though no standardized measure exists to independently evaluate English language ability. A review of the testing process performed by Coopers and Lybrand in 1997 found no standard test content and that testing instruments and scoring systems often varied across testing sites.<sup>1</sup> Given the subjective nature of the test, immigration officials are allowed to exercise "due consideration," or make allowances in certain cases based on an individual's education, age, background, and length of time in the United States. The 1997 study also found the extent of due consideration granted to be highly variable across testing sites.

## REVISITING THE SYSTEM

The United States is in the process of revising the content and purpose of its citizenship exam. It is not the only country considering a revision; there have

---

1 Department of Homeland Security, Office of the Inspector General, Letter Report: Citizenship Test Redesign, 2005.

been new initiatives in several European countries (Britain, the Netherlands, and Germany) to create citizenship exams that cover content beyond basic historical facts and that capture whether applicants share what are deemed to be core national values.<sup>2</sup>

## NATURALIZATION TRENDS 1990 TO THE PRESENT

In 2004, approximately 38 percent of the foreign-born population (13.1 million persons) were naturalized citizens.<sup>3</sup> The rate of naturalization among the foreign-born population has been steadily increasing since the early 1990s. Between 1994 and 2004, rates of naturalization increased by 232 percent over the previous decade.<sup>4</sup> This trend has held steady even in the face of record increases in immigration levels during the past two decades. A portion of the rise in naturalizations since 1994 can be attributed to the 1986 Immigration Reform and Control Act (IRCA), which granted legal status to 2.7 million unauthorized immigrants, thereby increasing the number of eligible applicants.<sup>5</sup> Other factors that played a role in rising naturalizations include the exclusion of non-citizens from certain public benefits by reforms introduced in 1996 and other heightened restrictions (expanding categories for deportable offenses, e.g.) for the non-naturalized population.

## NATURALIZATION BACKLOGS

Between 1997 and 2001, the federal government reported that the average processing time for US naturalization applications decreased from two years to between six and nine months. Applications are processed regionally however, and there were still significant variations in processing times due to existing backlogs. As of January 2006, district offices in Orlando, FL, and Charlotte, NC, were processing naturalization applications that were submitted in December 2004, while offices in Providence, RI, and Cincinnati, OH, were processing applications submitted as recently as October 2005.<sup>6</sup> US Citizenship and Immigration Services

---

2 Pilot tests have been introduced in the Netherlands and in Germany that attempt to test the values of applicants from certain countries or religious backgrounds against a set of “national values.” As an example, the Baden-Württemberg region of Germany has begun asking Muslims from Islamic countries an additional set of questions to elicit their beliefs on a range of domestic issues including women’s rights and religious freedom, to determine whether they should be granted citizenship. See E. Rothstein, “Refining the Tests that Confer Citizenship,” *The New York Times*, January 23, 2006.

3 A. Erlich and D. Dixon, “Spotlight on Naturalization Trends,” Migration Information Source (Washington, DC: Migration Policy Institute, November 1, 2005).

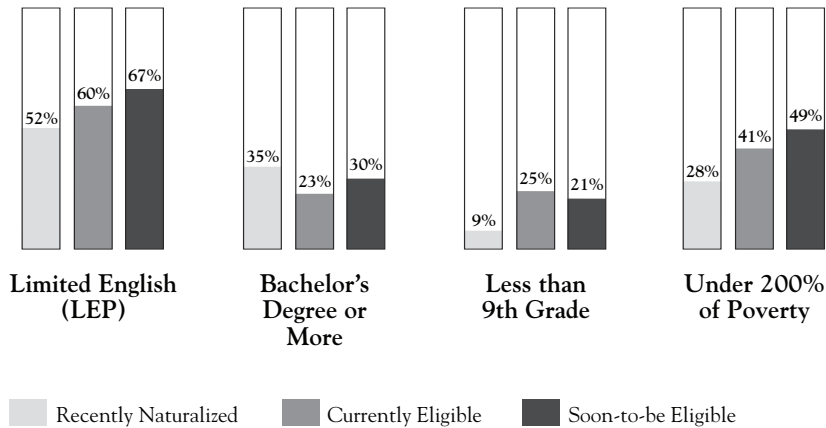
4 Ibid.

5 Ibid.

6 US Citizenship and Immigration Services Web site, <https://egov.immigration.gov/cris/jsps/ptimes.jsp>.

## FIGURE I. THE NATURALIZED SPEAK BETTER ENGLISH, HAVE MORE EDUCATION, AND HIGHER INCOMES

PERCENT OF AGES 25 AND OVER



Source: Urban Institute estimates are based on Census and CPS data. M. Fix, J. Passel, and K. Sucher, "Trends in Naturalization," Immigrant Families and Workers, Brief No. 3 (Washington, DC: The Urban Institute, September 2003).

(USCIS) has been working to eliminate the backlog of applications to ensure a six-month processing time for all applications.

### CHARACTERISTICS OF NATURALIZED AND "ELIGIBLE" POPULATIONS

Despite a high percentage of applicants who are granted citizenship (84 percent of all 2004 applicants received citizenship), there still remain a significant number of eligible persons who do not apply for naturalization. These include green card holders in the United States for five years or more or legal permanent residents married to US citizens in the United States for at least three years. This eligible population differs from the recently naturalized population in its English-language skills, education levels, countries of origin, income, immigration status, and settlement location in the United States. In many cases, its members face educational and linguistic barriers to naturalization.

- **A significant portion of the eligible population is limited English proficient.** Sixty percent of immigrants who were eligible to naturalize in 2000-

2001 were estimated to be limited English proficient (LEP). Additionally, 40 percent of the eligible population for this period indicated that they speak English either “not well” or “not at all.”

- **Individuals with low levels of education naturalize at lower rates.**<sup>7</sup> In 2000-2001, the portions of the eligible population that possessed less than a ninth-grade education or possessed at least a bachelor’s degree were roughly equal (25 percent and 23 percent, respectively). Thirty-five percent of the recently naturalized population was made up of college graduates versus only 9 percent with a ninth-grade education or less.
- **Rates of naturalization vary according to national origin.** Although Mexican immigrants make up the largest portion of the population that is eligible to naturalize, as a group they have not naturalized at a proportional rate. In 2001, Mexican immigrants made up 28 percent of the total eligible population but only 9 percent of naturalized citizens.
- **The eligible population also has lower income levels than those who have recently naturalized.** In 2000-2001, 41 percent of eligible immigrants had incomes under 200 percent of the federal poverty level and 17 percent were under the federal poverty level. In contrast, only 28 percent of recently naturalized citizens had incomes below 200 percent of the poverty level and 11 percent had incomes under the federal poverty level for this period.<sup>8</sup>
- **Refugees are more likely to naturalize than the rest of the eligible population.** During 2000-2001, refugees made up 14 percent of the eligible population but made up a significantly higher portion — 24 percent — of the recently naturalized population. Thus, refugees are 1.5 times more likely to naturalize than the non-refugee eligible population. This phenomenon may be in part due to ongoing conflict in their home countries that precludes any possibility of future return and to the variety of immigration-related programs and services (both public and private) that are available exclusively to refugee communities.<sup>9</sup>

---

7 M. Fix, J. Passel, and K. Sucher, “Trends in Naturalization,” *Immigrant Families and Workers*, Brief No. 3 (Washington, DC: The Urban Institute, September 2003).

8 Ibid.

9 Ibid.

# CURRENT FEDERAL POLICY ISSUES

## REDESIGNING THE CITIZENSHIP TEST

Despite demonstrated governmental interest in reforming the citizenship test, the redesign and the form it will take are currently uncertain. In December 2000, the Immigration and Naturalization Service (INS) began a formal test redesign initiative. The redesign has been aimed at improving both the content and administration of the test. Its main goals have been to (1) ensure that the test is administered in a standardized way across sites; (2) make the test a better, more meaningful gauge of the applicant's understanding of US history and civics; and (3) be fair and reliable. But achieving these multiple goals creates three basic tensions:

One tension is using simple English to test abstract concepts and ideas from US history and civics. The new test will need to evaluate applicants' understanding of complex ideas and concepts while using only the basic level of English required by the Immigration and Naturalization Act.<sup>10</sup> A second is balancing "due consideration" for individual cases with promoting standardization. A principal goal for the redesign process is the standardization of the exam across all testing centers. However, current regulations also dictate that test administrators should exercise "due consideration" and weigh test performance against an applicant's personal background.<sup>11</sup> A third is to create a meaningful test without affecting difficulty or increasing failure rates. USCIS has indicated that any changes that aim to make the citizenship exam a more meaningful tool will need to do so without affecting the current level of difficulty.<sup>12</sup>

In late 2006, the USCIS released new proposed questions for the citizenship test that will be pilot tested in selected sites. A new test is scheduled to be introduced in 2008.

---

10 Department of Homeland Security, "Letter Report" (see n. 1).

11 *Ibid.*

12 *Ibid.*

# ABOUT THE EDITOR AND CONTRIBUTORS

**Michael Fix** is Vice President and Director of Studies at MPI. He co-directs MPI's National Center on Immigrant Immigration Policy. His work focuses on immigrant integration, immigrant children and families, the education of immigrant students, and the effect of welfare reform on immigrants.

**Jeanne Batalova** is a Policy Analyst at the Migration Policy Institute.

**Amy Beeler** is Research Director at the Institute for Work and the Economy at Northern Illinois University.

**Deborah Garvey** is a Lecturer at the Department of Economics, Santa Clara University.

**Julia Gelatt** is a Research Assistant at the Migration Policy Institute.

**Adam Gurvitch** is the Director of Health Advocacy at the New York Immigration Coalition.

**Tamar Jacoby** is a Senior Fellow at The Manhattan Institute.

**Mary Helen Ybarra Johnson** was a research intern at the Migration Policy Institute.

**Donald Kerwin** is Executive Director of the Catholic Legal Immigration Network, Inc.

**Leighton Ku** is a Senior Fellow at the Center on Budget and Policy Priorities.

**Cecilia Muñoz** is the Vice President of the National Council of La Raza's Office of Research, Advocacy, and Legislation.

**Janet Murguía** is the President and CEO of the National Council of La Raza.

**Julie Murray** was an Associate Policy Analyst at the Migration Policy Institute.

**Demetrios G. Papademetriou** is the President and Co-Founder of the Migration Policy Institute.

**Renee Reichl** is a graduate student at the Department of Sociology at the University of California, Los Angeles.

**Roger Waldinger** is a Professor in the Department of Sociology at the University of California, Los Angeles.

# ABOUT THE MIGRATION POLICY INSTITUTE (MPI)

The Migration Policy Institute (MPI) is an independent, nonpartisan, non-profit think tank dedicated to the study of the movement of people worldwide. The institute provides analysis, development, and evaluation of migration and refugee policies at the local, national, and international levels. It aims to meet the rising demand for pragmatic responses to the challenges and opportunities that migration presents in an ever more integrated world. MPI also produces the Migration Information Source, an online journal with current migration data and analysis at [www.migrationinformation.org](http://www.migrationinformation.org).

## MPI'S NATIONAL CENTER ON IMMIGRANT INTEGRATION POLICY

In February 2007, MPI launched the National Center on Immigrant Integration Policy. The Center, co-directed by Michael Fix and Margie McHugh, will be a crossroads for elected officials, grassroots leaders, universities, think tanks, local service providers, state and local agency managers, and others who seek to understand and respond to the challenges and opportunities created by today's high rates of immigration. The Center will provide key services, including research, policy design, leadership development, technical assistance and training for government officials and community leaders, and an electronic resource center on immigrant integration issues with a special focus on state and local policies and data.

## THE INDEPENDENT TASK FORCE ON IMMIGRATION AND AMERICA'S FUTURE

The Task Force, a distinguished bipartisan panel of leaders and experts from key sectors concerned with migration, was convened by MPI in cooperation with the Manhattan Institute and the Division of United States Studies and the Mexico Institute at the Woodrow Wilson International Center for Scholars. The Task Force's purpose was to carefully evaluate the economic, social, and demographic factors driving today's large-scale immigration to

the United States, legal and illegal. Based on this analysis, the Task Force recommends that to harness the benefits of immigration and advance US national interests in the 21st century, the United States needs a new immigration policy and system. Its work has culminated in the recent publication, *Immigration and America's Future: A New Chapter*.

## ABOUT MPI'S RECENT PUBLICATION

### *IMMIGRATION AND AMERICA'S FUTURE: A NEW CHAPTER* SEPTEMBER 2006

For information on the Task Force, please visit [www.migrationpolicy.org](http://www.migrationpolicy.org). The full report can be purchased online for \$14.95, plus shipping, for global delivery (Visa and Mastercard only). The Executive Summary is available online in both English and Spanish.

Order online: [www.migrationpolicy.org](http://www.migrationpolicy.org)

Order by phone: 202-266-1908

Order by fax: 202-266-1900

For questions, please call 202-266-1908 or e-mail [info@migrationpolicy.org](mailto:info@migrationpolicy.org).

## SUPPORTING TASK FORCE PUBLICATIONS, BY TOPIC

### OVERVIEW

#### **Independent Task Force on Immigration and America's Future: The Roadmap**

By Michael Fix, Doris Meissner, and Demetrios G. Papademetriou, Migration Policy Institute

#### **Reflections on Restoring Integrity to the United States Immigration System: A Personal Vision**

By Demetrios G. Papademetriou, Migration Policy Institute

### THE UNAUTHORIZED POPULATION

#### **Unauthorized Migrants: Numbers and Characteristics**

Report by Jeffrey S. Passel, Pew Hispanic Center

#### **Twilight Statuses: A Closer Examination of the Unauthorized Population**

By David A. Martin, Migration Policy Institute and University of Virginia School of Law

#### **Lessons from the Immigration Reform and Control Act of 1986**

By Betsy Cooper and Kevin O'Neil, Migration Policy Institute

**The “Regularization” Option in Managing Illegal Migration More Effectively: A Comparative Perspective**

By Demetrios G. Papademetriou, Migration Policy Institute

**MEETING NATIONAL SECURITY AND IMMIGRATION ENFORCEMENT IMPERATIVES**

**Immigration Enforcement at the Worksite: Making it Work**

By Marc R. Rosenblum, Migration Policy Institute

**US Border Enforcement: From Horseback to High-Tech**

By Deborah W. Meyers, Migration Policy Institute

**Eligible to Work: Experiments in Verifying Work Authorization**

By Kevin Jernegan, Migration Policy Institute

**An Idea Whose Time Has Finally Come?**

**The Case for Employment Verification**

By Tamar Jacoby, Manhattan Institute

**Immigration Facts: Immigration Enforcement Spending Since IRCA**

By David Dixon and Julia Gelatt, Migration Policy Institute

**Documentation Provisions of the Real ID Act**

By Kevin Jernegan, Migration Policy Institute

**Countering Terrorist Mobility: Shaping an Operational Strategy**

Report by Susan Ginsburg, Migration Policy Institute

**Immigration Enforcement: Beyond the Border and the Workplace**

By David A. Martin, Migration Policy Institute and University of Virginia School of Law

**IMMIGRATION AND THE US LABOR MARKET**

**Temporary Worker Programs: A Patchwork Policy Response**

By Deborah W. Meyers, Migration Policy Institute

**“Comprehensive” Legislation vs. Fundamental Reform:**

**The Limits of Current Immigration Proposals**

By Marc R. Rosenblum, Migration Policy Institute

**The Growing Connection Between Temporary and Permanent Immigration Systems**

By Jeanne Batalova, Migration Policy Institute

**US Employment-Based Admissions: Permanent and Temporary**

By Susan Martin, Institute for the Study of International Migration, Georgetown University

**The Contributions of High-Skilled Immigrants**

By Neeraj Kaushal, Columbia University, and Michael Fix, Migration Policy Institute

**Immigrants and Labor Force Trends: The Future, Past, and Present**

By B. Lindsay Lowell, Institute for the Study of International Migration, Georgetown University; Julia Gelatt, and Jeanne Batalova, Migration Policy Institute

**The Impact of Immigration on Native Workers:  
A Fresh Look at the Evidence**

By Julie Murray, Jeanne Batalova, and Michael Fix, Migration Policy Institute

All of these publications can be downloaded as PDFs at  
<http://www.migrationpolicy.org/ITFIAF/publications.php>.

They can also be purchased through MPI's online bookstore at  
[www.migrationpolicy.org](http://www.migrationpolicy.org).

ACKNOWLEDGMENTS

Thanks go to the following organizations and foundations:

Carnegie Corporation of New York  
Charles Evans Hughes Memorial Foundation  
Evelyn and Walter Haas, Jr. Fund  
Ford Foundation  
Haas Foundation  
JEHT Foundation  
JM Kaplan Fund  
Manhattan Institute  
Open Society Institute  
Woodrow Wilson International Center for Scholars

Michael Fix would like to thank Julia Gelatt, Julie Murray, and Meg Weaver who were instrumental in pulling this volume together. He would also like to thank Doris Meissner, Director of the Independent Task Force on Immigration and America's Future and Senior Fellow at MPI, and Demetri Papademetriou, President and Co-Founder of MPI, for their guidance and support.