



**Center for the
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Ideas into Action

BRIEF FOUR

Consistent Health Coverage and Care

*Supporting the Health and Wellbeing of
Immigrant Families*

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Access to consistent health coverage and care is essential for the wellbeing of all families, and immigrant families are no exception. Yet despite their significant contributions to the nation’s economic, social, and cultural life, immigrants and their families are often prohibited from accessing the health programs that all families need to be healthy. This includes facing significant barriers to consistent coverage and care—barriers that extend far beyond what U.S.-born families already face.

To access care, immigrant families must navigate multiple systems that impose overlapping and often conflicting barriers that both confuse and discourage access. Immigration status can affect eligibility for health coverage programs like Medicaid, the Children’s Health Insurance Program (CHIP), and Affordable Care Act (ACA) Marketplace subsidies, with restrictive rules, waiting periods, and exclusions, leaving many families without affordable options. Even when families meet eligibility requirements for coverage, enrollment is often hindered by complex application processes, inadequate language support, limited culturally-responsive services, and fears that participation could jeopardize their immigration status or lead to enforcement actions. This constantly changing policy landscape contributes to the uncertainty immigrant families face about their eligibility for coverage and the implications of accessing the care they need. Together, these systemic and practical challenges combine to prevent consistent access to health care for immigrant families.

At the heart of the policies and practices that exclude immigrants from the coverage and care they need are false narratives that discount or ignore the enormous contributions they make to their communities

and the broader economy. Nowhere is this more evident than in health care, where immigrants make up a disproportionate share of physicians, nurses, and long-term care workers. Immigrants and their families deserve the same consistent, reliable access to care that they provide for so many others. Yet while immigrants provide critical care for others, their own family members are often denied it. These restrictions not only prevent families from seeking care but also weaken the broader public health system and underfund the health care workforce all communities depend on.

In this moment, policy is moving in the wrong direction—raising barriers to care for immigrant families. The 2025 federal budget and tax law (H.R.1) is expected to strip health coverage from 1.4 million lawfully-present immigrants by creating new Medicaid/CHIP eligibility restrictions that will exclude refugees, asylees, humanitarian parolees, and victims of human trafficking, among other, beginning in October 2026. In addition, five federal agencies have issued notices reinterpreting the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA) to expand the definition of “federal public benefit” to include programs that Congress never intended to restrict. Although a federal court issued a preliminary injunction blocking its enforcement, the ruling does not apply nationwide—leaving immigrant families and providers in an environment of uncertainty and fear.¹ At the state level, some state legislatures are passing anti-immigrant laws that create additional obstacles to state-funded care for immigrant families. One example is Idaho House Bill No. 135, which blocks undocumented immigrants from accessing public benefits previously exempt from immigration status verification (including publicly-funded vaccinations

1 On September 10th, the court in the State of New York, et al., v. USDOJ, et al., 25-cv-00345 (D.R.I.), granted the States’ Motion for a Preliminary Injunction—with the effect being that the Trump Administration’s new interpretation of “Federal public benefit” under the (PRWORA) may not be enforced or implemented in the plaintiff states while the case works its way through the judicial system. This injunction is not nationwide and only applies to the states involved in the litigation: New York, Washington, Rhode Island, Arizona, California, Colorado, Connecticut, Delaware, District of Columbia, Hawaii, Illinois, Maine, Maryland, Massachusetts, Michigan, Nevada, Minnesota, New Jersey, New Mexico, Oregon, Vermont and Wisconsin.

and prenatal and postnatal care for women). Furthermore, unprecedented changes to federal practices, like CMS [sharing Medicaid data](#) with immigration authorities,² have heightened fears that discourage families from seeking care.

Together, the actions taken by the Administration, Congress, and some states, like Idaho, are creating a chilling effect and leading to widespread fear and confusion—discouraging families from seeking services they are eligible for, leaving providers uncertain about compliance and prone to exclusionary practices, straining communities as unmet needs grow, and ultimately weakening public health and eroding trust in systems.

This brief examines both the eligibility restrictions that limit health coverage for immigrant families and the practical barriers that limit access to care. It then analyzes how recent shifts in federal policy exacerbate these barriers, before offering an inclusive vision for how policy changes can ensure access to consistent coverage that meets the needs of immigrant families—and in doing so, strengthen access to care for all families.

A Fractured Landscape: Eligibility Restrictions for Health Coverage

The U.S. health insurance system can be frustratingly complex and fragmented for everyone—but even more so for immigrant families, who face eligibility restrictions based not only on income, health status, and age, but also immigration status, how long they have held that status, and state of residence. Federal policymakers have willfully created these complicated restrictions for immigrant families. Some states, recognizing how these exclusions undermine the health and wellbeing of families and communities, have dedicated their own funding to create [programs](#) that fill the gaps. The result is a deeply unequal landscape in which access to affordable coverage and care depends heavily on where a family lives, in addition to their income, health status, immigration



status, and more. These complicated eligibility rules generate widespread confusion and are easily misunderstood by families, immigration attorneys, and even benefit administrators.

These restrictions do not just determine eligibility—they create fear and confusion and disrupt consistency in coverage. For example, a family seeking to enroll an eligible child in coverage is turned away when they cannot produce the required documentation, such as birth certificates or social security cards. Another, with two young children, must move for work—from a state that offers health coverage for undocumented immigrants to one that does not—losing their coverage overnight. A mother qualifies for limited coverage during pregnancy but loses it soon after giving birth, leaving her without access to critical postpartum care. Even children in mixed-status households who are eligible for coverage are [more likely to be uninsured](#), as parents face enrollment and language barriers, and fear immigration consequences or report confusion about eligibility. Together, these stories illustrate how [barriers](#)—eligibility restrictions, documentation requirements, time-limited coverage, and fear—undermine continuity in coverage and care for immigrant families. Appendix A illustrates how complex eligibility barriers can work together to reduce overall access to care for a mixed-status family. Although the visual presents a hypothetical family, all of the scenarios described are common occurrences for many immigrant families.

² On August 12, U.S. District Judge Vince Chhabria temporarily blocked the Trump administration from sharing Medicaid recipients' confidential information with immigration enforcement agencies.

In interviews CSSP conducted with immigrant families, this fractured approach comes into sharp focus.³ One mother described the difference between accessing care for her U.S.-born son and for her other children who were born outside the country, explaining, “no, they give him all the help (referring to her U.S. born baby). Ellos (referring to her other children) don’t have any help. If they get sick, it becomes very difficult for me because I have to pay for the consultation [...] Well, if he gets sick (referring to her U.S. born baby), they quickly attend to him with his insurance.” This story exposes how a patchwork of eligibility restrictions fractures families’ lives. Even within a single household, some children are recognized by policy while others are excluded—forcing parents to navigate impossible choices and endure fear and stress that undermine their families’ health and wellbeing.

The current fragmented landscape of immigrant health access stems from a series of exclusionary laws beginning in the 1970s that increasingly excluded different groups of immigrants from federal public health coverage programs like Medicaid and Medicare. These laws emerged from racist and xenophobic political mobilization that weakened federal benefit programs for everyone. Before this shift, no federal laws barred non-citizens—including undocumented immigrants—from accessing federally funded public benefits. Then, in 1972, when Congress created the Supplemental Security Income

(SSI) program, it explicitly excluded undocumented immigrants for the first time. That exclusion was used as justification for barring undocumented immigrants from other major benefits programs—including Medicaid, Aid to Families with Dependent Children (AFDC), food stamps, and unemployment insurance—not long afterward. A limited exception came in 1986, when the Emergency Medical Treatment and Labor Act (EMTALA) required hospitals to provide emergency stabilization care regardless of citizenship or immigration status, with states using Emergency Medicaid to cover those costs. Exclusionary laws were reinforced and expanded by the 1996 Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA), which imposed a five-year waiting period for many lawfully present immigrants and barred undocumented immigrants from nearly all federal means-tested programs, including Medicaid and CHIP. Undocumented immigrants are also barred from purchasing unsubsidized coverage through the ACA Marketplace. Their only pathways to coverage are employer-provided or state-funded coverage, but many do not work for employers or live in states that offer such coverage.

Practical Barriers to Consistent Coverage and Care for Immigrant Families

In addition to eligibility restrictions, immigrant families face a range of practical barriers that disrupt and discourage consistent access to health coverage and care. Language access is a key barrier. Many immigrant families report difficulty enrolling in public programs due to limited access to translation and interpretation services. Federal law under Title VI of the Civil Rights Act requires meaningful language access and applies across all federal agencies. While the legal responsibility to provide language access applies to all federal program areas and activities, including health care, implementation is often underfunded and uneven. In practice, many Medicaid agencies fail to provide translations beyond a handful



³ These interviews were conducted as part of a larger project aimed at understanding the needs of families who have recently crossed the southern border and immigrated to the United States, and the services currently available to meet those needs. As part of this research, we conducted semi-structured interviews with service providers and families in the Washington, D.C. metropolitan area between October and November 2019.

of the most widely spoken languages, leaving many families to rely on relatives or friends without specialized or clinical knowledge to translate. Even where interpretation services exist, families often encounter long wait times, untrained staff, [machine translation](#), or [artificial intelligence](#), all of which increase the risk of misunderstandings and medical errors. As an example, in [one study](#), families with limited English proficiency were more than five times likely to lose Medicaid during redetermination. The study found that language barriers—such as renewal notices provided only in English, forms that were difficult to complete, and reliance on children or relatives to interpret—played a key role in the cancellation of benefits.

Even when language access is not the main barrier, immigrant families often struggle to find culturally-responsive care—care that starts with the understanding that people come from diverse cultural, ethnic, religious, and socioeconomic backgrounds, and that respecting cultural factors (e.g., language, communication styles, beliefs, attitudes, and behaviors) is [crucial for proper health care](#) and results in [better health outcomes](#). Too often, providers lack the training and support to recognize and affirm the cultural values, lived experiences, and unique stressors facing certain immigrant groups, leading to misunderstandings, misdiagnoses, and underutilization of care. National [survey data](#) show that nearly three in ten immigrant adults report difficulties obtaining respectful, culturally-responsive care—citing concerns with



providers who fail to listen or explain things clearly, front-office staff who treat them with disrespect, and a lack of or delay in interpretation services. Truly culturally-responsive care [calls for system-wide investments](#) in a diverse and culturally knowledgeable workforce, bilingual staff and interpreter services (including qualified interpreter networks for less-commonly spoken languages), health promotion tools that incorporate culture-specific attitudes and values, and training to increase cultural awareness, knowledge, and skills, alongside partnerships with families, traditional healers, and community health workers to build trust with immigrant communities over time.

The pervasive fear of immigration-related consequences of accessing coverage and care is another key barrier to families' health and wellbeing—driven in large part by the [public charge](#) rule. First codified in 1882, and reinforced in the 1996 PRWORA, the public charge rule requires immigration officers to assess whether an applicant is likely to become primarily dependent on government support in certain immigration applications.⁴ Its interpretation has shifted over time, most notably in 2019 when the Trump Administration expanded the rule to include previously exempt benefits, such as Medicaid and nutrition assistance, in public charge determinations. This change led to a documented "[chilling effect](#)," with immigrant families avoiding supports like the Supplemental Nutrition Assistance Program (SNAP), Medicaid, and the Children's Health Insurance Program (CHIP), and forgoing essential services, including health care, out of fear that participation could jeopardize their future immigration status. Although the 2019 rule was blocked by federal courts and eventually rescinded by the Biden Administration, the chilling effect from the 2019 rule change never fully [resolved](#). Recently, the Trump Administration has proposed yet another drastic reinterpretation of the public charge rule. In addition to rescinding the Biden-era return to long-standing public charge norms, the newly proposed Trump rule leaves [public charge policy up to the guidance](#) of the Department of Homeland Security, using a more informal system that bypasses public oversight. Under Trump, federal agencies have also

⁴ The public charge test is used when applying for a visa to come to the United States from abroad or applying for a green card through a family member who is a U.S. citizen or permanent resident. See: [What You Need to Know About Public Charge](#).

chosen to restrict immigrants' eligibility for federal programs, further undermining community safety and trust, and leaving families uncertain about whether they can safely access the supports they need.

The fear of data sharing between state and federal agencies and immigration enforcement also discourages immigrant families from seeking care. Many immigrants are unsure whether the personal information required during enrollment or medical visits could later be used against them or their family members and lead to detention or deportation. These concerns are not unfounded. Recent federal actions have shown that personal data can be shared with immigration enforcement in ways that both disregard and violate long-standing privacy protections, further eroding trust and discouraging families from seeking the care they need. Without stronger safeguards, these practices will continue to deepen the chilling effect and drive immigrant families away from essential programs and services.

The Current Political Landscape

Today, federal policy continues to head in the wrong direction, undermining the health and wellbeing of families. We are seeing an active roll back of progress with policy decisions that are making communities less healthy, stripping immigrants of access to critical services that have long been in place, and even threatening to block U.S. citizens from programs they are eligible for by creating new barriers to eligibility. Legislative efforts, along with agency actions, are dismantling core health supports and likely to worsen access to care.

H.R.1, the sweeping budget law, includes several provisions that significantly undermine immigrant access to health care. One key way it does this is by cutting eligibility for Medicaid and CHIP down to only four categories of immigrants. This leaves several groups of immigrants newly ineligible for essential health coverage options, including refugees, asylees, and survivors of domestic violence with pending or approved lawful status under the Violence Against Women Act. The



Congressional Budget Office (CBO) estimates that these changes will leave another 100,000 individuals uninsured by 2034. Section 71110 of the budget law reduces the Federal Medical Assistance Percentage (FMAP) for emergency Medicaid services provided to undocumented immigrants. These services—already limited to life-threatening emergencies—are among the only federally reimbursable health services available to undocumented people. Lowering the FMAP from the Medicaid expansion rate of 90 percent to the standard rate disincentivizes hospitals and states from providing life-saving care, weakening a last-resort safeguard not only for immigrants but for entire communities. Emergency Medicaid was never designed to meet the full health needs of any population; its original purpose was to stabilize hospital finances. By cutting funding, H.R.1 destabilizes hospital finances, and places hundreds of rural hospitals at risk of closure.⁵ It prioritizes anti-immigrant ideology over public health and fiscal responsibility. Such provisions will strain health systems that serve large immigrant populations, particularly in urban areas, and likely lead to increased uncompensated care while worsening health outcomes.

H.R.1 compounds these harms by tripling funding for Immigration and Customs Enforcement (ICE), reinforcing fear and anxiety in immigrant communities and making engagement with public systems—including health care—more dangerous. Research confirms the consequences, showing that during periods of heightened enforcement, immigrant families are more likely to avoid routine activities such as going to the doctor or picking up prescriptions, even for

⁵ See this analysis: <https://www.kff.org/medicaid/a-closer-look-at-the-50-billion-rural-health-fund-in-the-new-reconciliation-law/>

U.S.-born children.

Additionally, the Trump administration’s proposed and enacted rollbacks of language access and civil rights protections threaten to erase decades of slow progress and put the health of patients with limited English proficiency at greater risk. In 2025, Executive order 14224 designated English as the official U.S. language and rescinded Executive Order 13166 which had required agencies to ensure meaningful access for limited English proficiency individuals. Soon after, the Department of Justice rescinded its longstanding guidance and directed agencies to scale back multilingual services. Together, these actions have undermined the legal rights of limited English proficiency individuals and reduced accountability for agencies that fail to provide meaningful access, and undermined immigrant families’ access to care. This rollback in civil rights enforcement directly contradicts public health goals and disproportionately harms immigrant populations already facing numerous barriers to care.

Even hard-won victories to expand access to care and coverage are fragile in this shifting landscape. In November 2024, the Biden administration issued a final rule allowing DACA (Deferred Action for Childhood Arrivals) recipients to purchase coverage through the ACA Marketplace for the first time, after more than a decade of exclusion. But a federal court quickly blocked DACA recipients in 19 states from enrolling, and the Trump administration has since revoked their eligibility altogether. As of August 15, 2025, the few DACA recipients who were able to enroll in ACA Marketplace coverage during the prior nine months



lost coverage and are once again barred from the Marketplace. This reversal underscores how gains in immigrant health access are fragile, easily dismantled, and leave families with constant uncertainty.

Taken together, these efforts demonstrate a pattern of instability. For immigrant families, the policy landscape is constantly shifting—eligibility rules change from year to year, and even when families remain eligible, confusion and fear can lead them to avoid programs or to disenroll. Coverage is especially tenuous when it depends on state or local programs, which can expand or contract based on political will or budget constraints. The result is a fractured landscape where immigrant families cannot count on consistent, reliable coverage—precisely the foundation needed for good health and continuity of care.

At the same time, campaigns of indiscriminate immigration enforcement and harassment have heightened stress in immigrant communities and further discouraged families from seeking care. Workplace raids, like those at an Omaha meat production plant in June, leave families without income overnight and spread fear far beyond the targeted sites. Arrests in or near hospitals and clinics have been documented, making families reluctant to seek even emergency care. Increased enforcement at schools and courthouses have disrupted community trust, with families avoiding places they once considered safe. And the use of public records, such as DMV and Medicaid data, for immigration enforcement has raised alarm that applying for benefits or even seeking care could expose families to risk. The result is a landscape in which health access is never secure, leaving families with persistent uncertainty about whether they will be able to get the care they need and fearing the consequences of seeking care.

A Positive Vision Is Still Possible

The fractured nature of the U.S. health care and immigration systems creates significant and enduring obstacles to coverage and care for immigrant families. These challenges are both systemic and practical—rooted in exclusionary laws, Congressional failure to act in the best interest of families, discriminatory rhetoric, and deliberate underinvestment in

linguistically-appropriate and culturally-responsive care. As federal policy continues to shift toward exclusion and enforcement, the pressure on states and communities to fill the health access gaps for immigrant families has increased. Some states have responded with innovative approaches, but the result is a patchwork and uneven access landscape that varies based on geography, political climate, and program capacity. Nevertheless, the policy vision driving these innovations is one that has the potential to safeguard access to health coverage and care for all.

The U.S.—where one in four children live in immigrant families—cannot achieve health equity or guarantee family wellbeing without ensuring consistent health access for all families, regardless of immigration or citizenship status. The exclusion of immigrant families from consistent coverage and quality health care has ripple effects that extend beyond individual households—it undermines public health, widens racial and economic disparities, and erodes trust in public institutions. Immigrant families are an integral part of our society and deserve a health care system that recognizes their contributions and their humanity.

A more just and effective approach would eliminate harmful exclusions, extend comprehensive coverage to all income-eligible people regardless of immigration status, and prioritize linguistically-accessible, culturally-responsive care. Such a system would not only promote better health outcomes for immigrants, but also create stronger, more resilient communities for everyone.

To achieve this vision, policymakers should take the following steps:

- **Guarantee coverage for all.** Develop a comprehensive health insurance program that is available to all children and families—regardless of immigration status.
- **End federal exclusions and waiting periods for coverage.** Repeal H.R.1’s eligibility restrictions and PRWORA’s five-year bar for Medicaid/CHIP coverage.
- **Ensure coverage pathways regardless of status.**

Allow all immigrants to purchase Marketplace coverage regardless of status and codify DACA recipients’ eligibility for Medicaid, and ACA coverage, including subsidies.

- **Reverse restrictive federal agency actions.** Rescind the 2025 reinterpretations of “federal public benefit” under PRWORA and codify the 2022 DHS public charge rule to reduce chilling effects and provide clarity for immigrant families as well as legal and social service providers.
- **Strengthen language access in health care.** Fully enforce existing Title VI obligations in Medicaid, CHIP, and the ACA Marketplace; require and fund greater access to translated applications and qualified interpreters, including through grants to immigrant-serving organization; hold agencies accountable through compliance plans and public reporting.
- **Simplify coverage enrollment and renewal processes.** Ensure plain-language, multilingual applications and renewal notices, and simplify and streamline enrollment and renewals (e.g., ex-parte renewals) so eligible families do not lose coverage due to administrative barriers, confusion, or language access gaps.
- **Protect privacy.** Codify the prohibition against using or sharing of health and benefit enrollment data for immigration enforcement and strengthen safeguards to rebuild trust in public systems.

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Read the full *Consistent Health Coverage and Care* compendium of briefs.

Appendix A: A Mixed-Status Family's Health Journey

Mona is undocumented and thus generally barred from federal-funded insurance like Medicaid. Because she is pregnant and lives in one of the 24 states that offers prenatal care regardless of immigration status (FCEP), Mona is able to receive prenatal care through the end of her pregnancy.



David is a green-card holder who is still inside the 5-year waiting period before he can be eligible for Medicaid. He had employer-provided insurance when he first arrived but lost it when he was laid off last year. His new job does not offer insurance and the family cannot afford marketplace insurance.



Nina is a 12-year-old green-card holder who is still inside the 5-year waiting period. However, because the family lives in one of the 37 states that opted to cover “qualified” immigrant children without a 5-year wait, Nina has health insurance through her state’s Medicaid/CHIP program.

