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Permalink

<https://escholarship.org/uc/item/8g97z0hw>

Journal

Journal of Health Politics Policy and Law, 50(6)

ISSN

0361-6878

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Publication Date

2025-12-01

DOI

10.1215/03616878-11995160

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Shifting Federal and State Policy Landscapes for Health Insurance Coverage of Noncitizen Immigrants: Where Are We 30 Years After PRWORA?

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Abstract Since the 1996 passage of the Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA), states have taken different approaches to non-citizen health coverage. California and Illinois used state funds to expand access, driven by policy innovation and advocacy coalitions, while Texas and Georgia maintained restrictive policies that reflected conservative politics and fiscal concerns. This study used the policy diffusion and policy context frameworks to analyze PRWORA's influence on state decisions about immigrant health coverage. By examining the policy trajectories of California, Illinois, Texas, and Georgia, the authors highlighted the growing fragmentation in immigrant health coverage. The study reviewed trends in health insurance and Medicaid enrollment among noncitizens from 2008 to 2023 using data from the American Community Survey and a RAND cost estimation tool. California and Illinois showed greater improvements in insurance coverage and Medicaid enrollment, while Texas and Georgia had lower gains. The authors found that restrictive policies led to higher uninsured rates and different trade-offs in terms of cost and potential enrollment of noncitizens into Medicaid. Future policy developments will likely be influenced by federal policy changes, demographic shifts, and advocacy efforts. Understanding these dynamics is important for addressing disparities in immigrant health care access and for informing policy debates.

Keywords immigration, PRWORA, Medicaid, health insurance coverage, state policies

The 1996 passage of the Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA) marked a major shift in US social and health policies, particularly for noncitizen immigrants. PRWORA restricted access to federal public programs—including Medicaid, Supplemental Security Income, and Temporary Assistance for Needy Families—for most immigrants, especially undocumented immigrants and those who had been residing in the United States for fewer than five years, except for emergency Medicaid. That same year, Congress also passed the Illegal Immigration Reform and Immigrant Responsibility Act (IIRIRA), which expanded mechanisms for immigration enforcement (Bitler and Hoynes 2011). While PRWORA aimed at welfare reform, IIRIRA made it more difficult for noncitizens to qualify for deportation relief and increased penalties for immigration violations. It also codified the Public Charge Ground of Inadmissibility final rule (or “public charge” rule), allowing immigration officials to consider an immigrant’s use of public assistance when determining visa or permanent residency eligibility (Kolker and Heisler 2024). Together, PRWORA and IIRIRA reinforced restrictions on immigrant access to public benefits, marking a turning point in US social policy and signaling a shift toward more restrictive immigration and health policies that continues today.

Under PRWORA, states could either impose additional restrictions or expand coverage using their own funds. By limiting access to federally funded public benefits like Medicaid and the Children’s Health Insurance Program (CHIP), PRWORA created significant coverage gaps for immigrant populations. Research has shown that PRWORA led to higher uninsured rates and poorer health care access for immigrants when compared to the general population (Kaushal and Kaestner 2005; Viladrich 2012). Studies have focused particularly on the pervasive effects among immigrant women and children living in mixed-status households where at least one family member is an undocumented immigrant and at least one is a US citizen (Kaushal and Kaestner 2005; Metsch and Pollack 2005; Perreira and Pedroza 2019). Since its passage, PRWORA has increased stratification of immigrants by legal status, creating structural discrimination in access to public programs (Acevedo-Garcia et al. 2021). Over the nearly three decades since PRWORA’s enactment, both federal and state policies on immigrant health coverage have evolved through a mix of restrictions

and expansions, influenced by shifting political ideologies, economic pressures, and advocacy efforts (Vargas Bustamante et al. 2021).

While federal policies have largely maintained barriers to immigrant health coverage, key legislative and executive actions have introduced incremental expansions. The 2009 CHIP Reauthorization Act allowed states to extend Medicaid and CHIP benefits to lawfully present immigrant children and pregnant women without the five-year waiting period, a provision adopted by 30 states (Pillai, Pillai, and Artiga 2024). The 2010 Affordable Care Act (ACA) permitted lawfully present immigrants to purchase subsidized insurance through state marketplaces. However, undocumented immigrants remained ineligible for Medicaid, CHIP, and ACA subsidies, with Deferred Action for Childhood Arrivals recipients explicitly excluded until 2024, when the Biden administration extended ACA access to this group (KFF 2025a). By contrast, restrictive policies, such as the Trump administration's 2019 expansion of the public charge rule, had chilling effects on immigrants' enrollment in public programs as a result of fears of jeopardizing their legal statuses or that of family members (Vargas Bustamante et al. 2022). Recent policy proposals, including potential Medicaid funding cuts and stricter eligibility criteria, continue to influence state-level decision-making on immigrant health coverage.

Amid federal constraints, states have played a crucial role in determining access to health care for noncitizens. States like California and Illinois have adopted expansionary policies using state funds to cover income-eligible undocumented immigrants and lawfully present immigrants with fewer than five years of US residence, including children, older adults, and pregnant women (Heyison and Gonzales 2024). Other states, such as Texas and Georgia, have maintained limited access to publicly funded health care regardless of economic or public health considerations (Young and Wallace 2019). These divergent policy choices reflect political, economic, and demographic trends that influence state-level decision-making.

This article uses the policy diffusion and policy context frameworks to examine the evolution of state health policies for noncitizens in the post-PRWORA era. Through a comparative case study method, it analyzes the policy trajectories of two states that have expanded coverage (California and Illinois) and two that have maintained restrictive policies (Texas and Georgia). The study explores the mechanisms of policy diffusion—learning, imitation, competition, coercion, and pressure—that have influenced these divergent approaches. We argue that immigrants in each of these states face different combinations of integration and criminalization policies, which create different policy environments that affect their access to health care.

By examining the different factors shaping state-level decisions, this study aims to review different state policies toward immigrant health coverage and their outcomes. As the 30th anniversary of PRWORA approaches, understanding these dynamics is critical for informing future policy debates on immigrant health access in the United States.

Policy Diffusion and Policy Context Frameworks

Policy diffusion provides a framework to analyze how states' policies on immigrant health coverage evolve in response to external influences and internal factors (Shipan and Volden 2008). Previous research has used this framework to analyze the origins and implications of different state health policies (Gollust, Nagler, and Fowler 2020; Grogan 2025; Karch 2007). Policy diffusion explains how policies spread across jurisdictions and the factors that influence states to adopt or resist policy changes. Applied to immigrant health policy, this framework operates through four different mechanisms (Shipan and Volden 2008). *Learning* occurs when states observe the impact of other states' policies and adopt those that prove effective. For example, Illinois expanded immigrant health coverage after learning about California's early implementation. *Imitation* involves states following ideological or political models from similar states, such as conservative states adopting restrictive policies for immigrants in alignment with broader trends. *Competition* considers economic factors, such as labor market needs and cost control, leading some states to expand coverage to improve public health and economic stability. *Coercion and pressure* happen when courts, advocacy groups, or federal incentives push states toward certain policy directions, exemplified by lawsuits and legal challenges that have led to increased health access in some states. These mechanisms—learning, imitation, competition, and coercion and pressure—offer insights into how state policy making evolves over time.

Since the enactment of PRWORA, policy fragmentation has created diverse policy environments for noncitizens in each state, characterized by different combinations of integration and criminalization policies (Young and Wallace 2019). *Integration policies* expand eligibility and rights for immigrants, facilitating their access to health-promoting resources regardless of citizenship status and reducing inequality between noncitizens and citizens. Examples include providing CHIP benefits and prenatal care regardless of legal status, extending labor and employment protections to immigrants, allowing professional licensing of undocumented professionals, and paying for interpreters through Medicaid or CHIP. By

contrast, *criminalization policies* regulate the “legality” of noncitizens’ daily lives, increasing their exposure to immigration enforcement through surveillance and control. These policies create a risk of deportation for all noncitizens and can lead to acute stress and long-term discrimination based on legal status. Examples include requiring a Social Security number for a driver’s license, complying with the Real ID Act, mandating the use of E-Verify, and states collaborating with federal immigration authorities. According to the framework, state-level policies can be classified into four policy context types based on different policy combinations of integration and criminalization policies. Both the policy diffusion framework and the policy context framework are used in four case studies below to examine post-PRWORA state policy choices regarding health coverage for noncitizens.

Research Design and Data Analyses

This study uses a comparative case study approach to analyze the divergent policy responses of four states—California, Illinois, Texas, and Georgia—regarding health coverage for noncitizens. California and Illinois serve as examples of expansionary policies, as they have implemented state-funded programs to close coverage gaps left by PRWORA (Heyison and Gonzales 2024). By contrast, Texas and Georgia exemplify restrictive policies by maintaining exclusions and offering only limited safety net services for immigrant populations (Broder 2025). These states show regional, political, and demographic variation, which allows for comparative analyses in policy choices.

We use American Community Survey (ACS) data to describe uninsured rates from 2008 to 2023 and Medicaid enrollment among noncitizens since the passage of PRWORA in the four case studies. For each state, we include descriptive statistics of the noncitizen population and state-level measures for 2008 and 2023. We run probit regressions separately to estimate predicted probabilities (reported as marginal effects) of having any health insurance coverage and Medicaid for noncitizens in each state. We conducted the analyses using Stata MP18 and applied survey weights.

We use a RAND-developed policy tool to evaluate the policy choices to expand health coverage to noncitizens encountered by each state (Rao et al. 2024). This tool pools data from different sources such as ACS, the Medical Expenditure Panel Survey, the Migration Policy Institute, and the Center for Migration Studies. It estimates the number of undocumented immigrants and recently arrived lawfully present immigrants in each state and

the potential enrollment to full-scope Medicaid under three take-up scenarios. By estimating the uninsured noncitizen population in each state, this tool provides estimates of the potential costs of expanding coverage to noncitizen immigrants in each state. This type of cost estimation forecast has been used in previous cost research (Vargas Bustamante et al. 2019). By integrating these sources, this study aims to understand the cost and enrollment trade-offs that could explain the different policy approaches states have taken to expand health coverage to noncitizens.

Case Studies

California

California's approach to noncitizen health coverage has evolved significantly over the past three decades and has balanced inclusive and restrictive policies. In 1994, Californians passed by 59% a ballot initiative, Proposition 187, that sought to deny undocumented immigrants access to public benefits, including health care, and required public employees to report suspected undocumented individuals to federal authorities. Although eventually ruled unconstitutional by federal courts, Proposition 187 significantly influenced the national debate on immigration and public benefits (Zimmermann and Tumlin 1999), preceding federal policies such as PRWORA and IIRIRA.

Following the passage of Proposition 187 in 1994, a strong backlash, particularly from Latino and immigrant communities, led to increased political mobilization, which shifted California's electorate toward the Democratic Party. Despite Governor Pete Wilson's continued tenure, demographic changes and opposition to anti-immigrant policies prompted the state legislature to use state funds to mitigate the effects of the PRWORA on noncitizen immigrants (Morain 2019). This period marked the beginning of a long-term political realignment, as California transitioned from restrictive immigration policies to a more inclusive approach, which ultimately solidified Democratic dominance in state politics.

After California became one of the first states to use state funds to cover lawfully present noncitizens excluded under PRWORA, a series of health care expansions to address coverage gaps for immigrants followed. In 1999, the state introduced the Health Care for All Kids program, which provided health care to low-income children regardless of immigration status (Broder 2025). California also preregistered adults for emergency Medicaid to ensure access to emergency care for those who meet all

Medicaid requirements except immigration status. In 2015, Medi-Cal (the state's Medicaid program) began covering undocumented children. Alongside these state-level initiatives, local programs such as Healthy San Francisco and MyHealth LA provided coverage to income-eligible residents regardless of their immigration statuses, further expanding limited health coverage to uninsured noncitizens (Bustamante and Felix-Beltran 2020). From 2020 to 2024, California extended Medi-Cal coverage to undocumented adults (KFF 2025a). In 2024, all low-income undocumented adults became eligible for Medi-Cal, marking a significant milestone in the state's health care expansion.

California's evolving policy approach illustrates mechanisms of policy learning and diffusion. The state learned from its earlier programs, such as emergency Medicaid, Healthy Families, and local initiatives (e.g., Healthy San Francisco, MyHealth LA), to estimate the costs and challenges of expanding Medicaid to noncitizens. These programs served as prototypes for broader Medicaid expansions and became models for other states, reinforcing the role of imitation in policy diffusion. Other states with similar political coalitions and local economies reliant on immigrants' labor also expanded coverage for noncitizens and contributed to a growing national trend (KFF 2025a).

Competition and political pressure significantly influenced California's policy choices. Recognizing the economic benefits of a healthier immigrant workforce, the state's legislators believed that expanding health care access would reduce uncompensated care costs and stabilize labor markets. The growing number of aging noncitizen immigrants, who are largely ineligible for Medicare because of PRWORA exclusions, increased the need for expanding insurance coverage (Vargas Bustamante et al. 2021). Advocacy pressure from health care and immigrant rights organizations, such as the California Immigrant Policy Center, Health Access California, and the Coalition for Humane Immigrant Rights, played key roles in advocating for Medicaid expansion to undocumented immigrants through initiatives like the Health4All Coalition and local health programs that pressured policy makers to extend coverage despite fiscal concerns (Vargas Bustamante et al. 2023).

These external pressures, along with demographic shifts and the need for equitable health care, drove legislators of California's Latino Caucus to push for expansion of the state's Medicaid program. However, immigrant health care coverage in California may be at risk as federal Medicaid cuts loom in 2025. Facing significant budget pressure, the state may be unable to absorb reductions in federal funding, which accounted for about 64% of

Medi-Cal spending, with California covering the remaining 36% in 2023 (NASBO 2024).

Expansionary health policies were complemented by practical measures to ease daily life for noncitizens, such as issuing driver's licenses to undocumented immigrants. According to the policy context framework, California is a high integration, low criminalization state, which means California has many policies that expand rights and access to resources for immigrants while having few policies that increase their risk of immigration enforcement. This creates a proactive inclusion context, where noncitizens are protected from deportability and actively included (Young and Wallace 2019). Together, these policies demonstrate how California's noncitizen health policies evolved in response to state politics as well as internal needs and external influences, creating a model that other states could replicate as they addressed the health care needs of their noncitizen populations.

From 2008 to 2023, the share of noncitizen immigrants with health insurance increased significantly, from 55.4% to 79.6%, while Medicaid coverage also grew substantially, rising from 15.9% to 32.9% (table 1). Enrollment in Medicaid accelerated after the ACA expansion and the 2022–2024 expansion to undocumented immigrants. During this period, demographic and socioeconomic changes among noncitizens in California, such as higher educational attainment, increased income, and greater English proficiency, could have contributed to increased enrollment (table 1). When these factors are considered, the marginal effects models showed significant increases in the likelihood of having any health insurance from 2014 onward, with the highest increase observed in 2023 (fig. 1, table 2). Similarly, the likelihood of having Medicaid health insurance for noncitizen immigrants with household incomes below 200% of the federal poverty level increased significantly, particularly from 2010 onward, with the highest increase in 2023 (fig. 2, table 3). In 2022, California had an estimated undocumented immigrant population of 2.5 million, with 39.1% uninsured. Predicted Medicaid enrollment in 2022 for income-eligible uninsured undocumented immigrants and lawfully present immigrants with fewer than five years of US residence ranged from 361,800 to 494,400, with average state spending per enrollee of \$7,700 (table 4).

Illinois

Illinois has developed a progressive approach to immigrant health care over several decades, marked by key policy milestones addressing the needs of

Table 1 Weighted Descriptive Statistics by State, 2008 vs. 2023

	Total	California	Illinois	Texas	Georgia	<i>p</i>
Health insurance coverage 2008^a						
Any health insurance	49.67	55.43	55.19	37.86	40.13	<0.000
Any public health insurance	14.73	19.00	11.89	9.27	4.61	<0.000
Any Medicaid health insurance	11.87	15.92	8.26	6.91	2.86	<0.000
Health insurance coverage 2023^a						
Any health insurance	68.53	79.54	72.14	52.93	57.25	<0.000
Any public health insurance	26.16	38.15	22.84	12.10	9.82	<0.000
Any Medicaid health insurance	21.44	32.93	17.16	8.14	6.42	<0.000
Sex						
2008 Female	46.55	47.45	45.75	46.00	42.15	<0.000
2023 Female	47.76	48.12	47.28	47.36	47.67	0.2939
Race/ethnicity 2008						
Non-Latino white	10.11	9.50	20.47	6.54	14.19	<0.000
Non-Latino Black	2.38	1.18	2.95	2.83	10.34	
Latino	69.8	68.32	57.95	80.33	56.64	
Other	17.71	21.00	18.63	10.31	18.83	
Race/ethnicity 2023						
Non-Latino white	8.14	8.93	16.02	4.84	7.31	<0.000
Non-Latino Black	3.15	1.06	4.21	4.36	11.26	
Latino	65.20	62.7	55.13	74.07	54.9	
Other	23.51	27.3	24.64	16.72	26.53	
Age						
2008 Younger than 18	9.67	8.93	9.06	10.85	12.25	<0.000
18–25 years old	14	13.67	14.93	14.02	15.43	
26–49 years old	57.24	56.91	57.5	57.62	58.11	
50–64 years old	13.39	14.2	12.71	12.7	10.1	
65 or older	5.70	6.29	5.80	4.81	4.11	
2023 Younger than 18	8.41	6.75	8.42	10.43	10.93	<0.000
18–25 years old	9.11	8.47	9.08	9.89	10.08	
26–49 years old	52.05	51.08	52.98	52.37	56.33	
50–64 years old	21.37	23.31	20.04	19.78	16.54	
65 or older	9.07	10.4	9.49	7.53	6.12	
Marital status						
2008 Married	53.28	51.82	55.16	56.22	50.53	<0.000
2023 Married	54.38	53.91	54.14	55.19	54.30	0.0213
Education						
2008 High school or less	74.66	73.82	69.4	79.35	70.34	<0.000
2023 High school or less	67.40	67.25	61.32	69.77	65.38	<0.000

(continued)

Table 1 Weighted Descriptive Statistics by State, 2008 vs. 2023 (*continued*)

	Total	California	Illinois	Texas	Georgia	<i>p</i>
Employment						
2008 Employed	59.54	58.81	62.18	59.16	63.4	<0.000
2023 Employed	61.26	61.22	62.52	60.66	62.73	0.0748
English proficiency						
2008 Not well	48.38	49.25	41.45	51.12	39.92	<0.000
2023 Not well	40.67	41.42	34.98	42.59	33.76	<0.000
Household income (% FPL) 2008						
> 200%	48.93	50.97	57.59	41.18	49.99	<0.000
100–200%	30.89	29.91	27.23	34.39	30.48	
<100%	20.18	19.12	15.19	24.43	19.54	
Household income (% FPL) 2023						
> 200%	60.12	62.71	65.23	54.52	60.94	<0.000
100%–200%	23.59	23.06	19.74	25.45	23.86	
<100%	16.29	14.23	15.04	20.03	15.20	

Sources: American Community Survey 2008 and 2023.

Notes: Values are shown as column percent. FPL = federal poverty level.

^aEach health insurance category has its own column percent, and values reported represent the percentage of respondents with that given insurance.

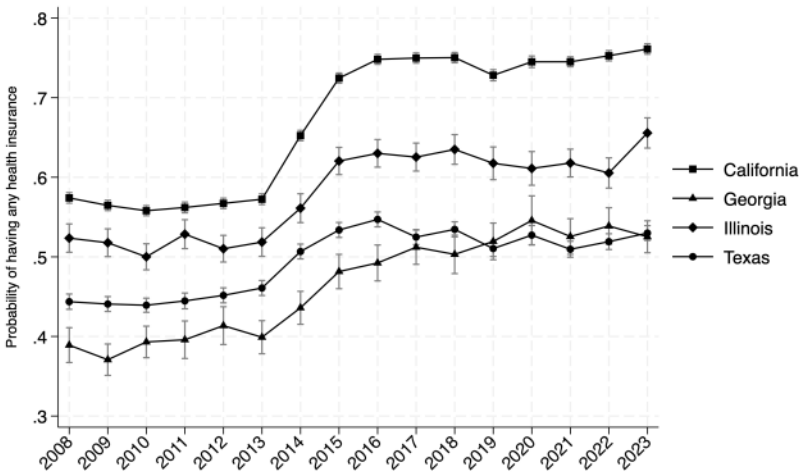


Figure 1 Marginal probabilities of having any health insurance for noncitizen immigrants, American Community Survey 2008–2023.

Table 2 Marginal Effects of Year on Having Any Health Insurance by State for Noncitizen Immigrants

Year	California	Illinois	Texas	Georgia
2008	<i>ref</i>	<i>ref</i>	<i>ref</i>	<i>ref</i>
2009	−0.94*	−0.58	−0.30	−1.83
2010	−1.61**	−2.35	−0.45	0.40
2011	−1.20*	0.50	0.10	0.68
2012	−0.68	−1.33	0.79	2.45
2013	−0.17	−0.50	1.72*	0.99
2014	7.84***	3.76**	6.30***	4.69**
2015	15.05***	9.69***	9.01***	9.25***
2016	17.41***	10.65***	10.34***	10.33***
2017	17.57***	10.18***	8.12***	12.30***
2018	17.63***	11.14***	9.08***	11.40***
2019	15.41***	9.40***	6.67***	13.03***
2020	17.10***	8.76***	8.36***	15.66***
2021	17.10***	9.43***	6.59***	13.65***
2022	17.86***	8.18***	7.54***	14.97***
2023	18.71***	13.21***	8.62***	13.61***

Source: American Community Survey 2008–2023.
Notes: Marginal effects are shown as percentages, with 2008 as the reference group. All models were adjusted for sex, race/ethnicity, age, marital status, education, employment status, English proficiency, and household income. * $p < 0.05$, ** $p < 0.01$, *** $p < 0.001$

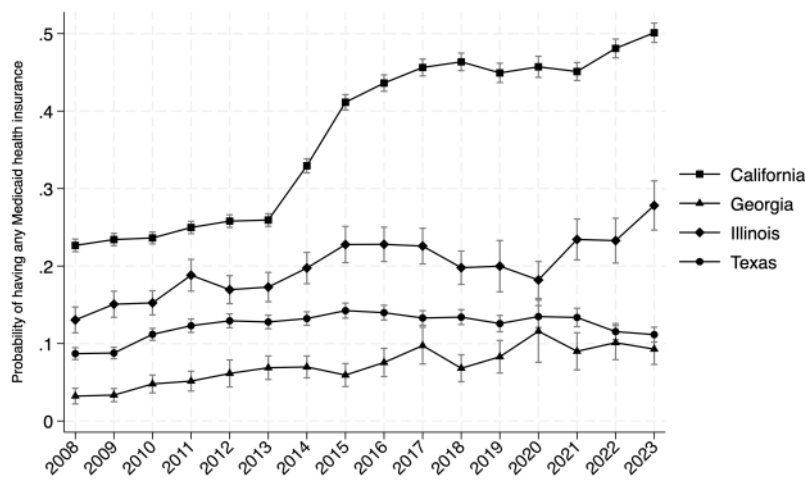


Figure 2 Marginal probabilities of having any Medicaid health insurance for noncitizen immigrants with household income <200% of the federal poverty level, American Community Survey 2008–2023.

Table 3 Marginal Effects of Year on Having Any Medicaid Health Insurance by State for Noncitizen Immigrants with Household Income <200% FPL

Year	California	Illinois	Texas	Georgia
2008	<i>ref</i>	<i>ref</i>	<i>ref</i>	<i>ref</i>
2009	0.76	2.03	0.08	0.13
2010	0.97	2.20	2.49***	1.57*
2011	2.32***	5.77***	3.60***	1.93*
2012	3.14***	3.91**	4.24***	2.93**
2013	3.27***	4.24**	4.09***	3.66***
2014	10.27***	6.70***	4.53***	3.76***
2015	18.48***	9.73***	5.55***	2.71**
2016	20.95***	9.76***	5.29***	4.33***
2017	22.96***	9.53***	4.60***	6.52***
2018	23.69***	6.74***	4.71***	3.59***
2019	22.27***	6.94***	3.88***	5.08***
2020	23.05***	5.16**	4.79***	8.37***
2021	22.44***	10.39***	4.67***	5.78***
2022	25.43***	10.23***	2.84***	6.90***
2023	27.45***	14.77***	2.46***	6.06***

Source: American Community Survey 2008–2023.

Notes: FPL = federal poverty level. Marginal effects are shown as percentages, with 2008 as the reference group. All models were adjusted for sex, race/ethnicity, age, marital status, education, employment status, English proficiency, and household income. * $p < 0.05$, ** $p < 0.01$, *** $p < 0.001$

noncitizens. In 1996, following California, Illinois used state funds to cover lawfully present noncitizen immigrants with fewer than five years of US residence after PRWORA's approval. Since the early 2000s, Democrats have consistently held the governorship and majorities in the state legislature, creating favorable conditions for passing progressive policies. This political alignment, along with demographic changes such as population growth and increasing diversity in urban and suburban areas, has helped shape the types of policies pursued during this period (US Census Bureau 2023). Since 2002, Illinois has provided limited coverage for children, parents, and disabled immigrants. In 2006, Illinois enacted the All Kids program advanced by state Democratic legislators and became the first US state to offer universal coverage to children, regardless of immigration or income status, and to pregnant individuals through pregnancy and postpartum care (Heyison and Gonzales 2024). In 2021, the state further expanded health care access for adult noncitizens with the creation of the Health Benefits for Immigrant Seniors (HBIS) program, which provides

Table 4 Coverage and Costs Associated with State-Funded Health Insurance Coverage for Noncitizens

State	Undocumented immigrant population (N)	Undocumented immigrant population (%)	Uninsured undocumented population (%)	Uninsured undocumented (% of undocumented)
California	2,495,000	6.4%	974,000	39.1%
Texas	1,760,000	5.9%	1,171,000	66.5%
Illinois	408,000	3.2%	200,000	48.9%
Georgia	335,000	3.1%	216,000	64.5%

Medicaid enrollment and cost forecast in three scenarios

State	Predicted low take-up rate	Predicted medium take-up rate	Predicted high take-up rate	Average state spending per enrollee
California	361,800	419,500	494,400	\$7,700
Texas	312,500	362,000	391,300	\$5,300
Illinois	79,000	92,000	99,200	\$7,100
Georgia	44,700	51,800	56,000	\$7,200

Source: ACCESS Estimator, RAND (2024).
Notes: To estimate state-level data on undocumented immigrants, this tool uses 2022 data from the American Community Survey, 2024 data from the Public Use Microdata Sample, data from the Migration Policy Institute, and 2022 data from the Center for Migration Studies. To estimate the per capita cost of enrolling undocumented immigrants and recent legally present immigrants with fewer than five years of residence, this tool used data from the 2018–2019 Medical Expenditure Panel Survey. Results show Medicaid enrollment forecasts for uninsured undocumented immigrants and recent legally present immigrants per state under three different scenarios. Take-up rates for the low scenario is 69% for adults and 81% for children, and rates for the high scenario are 87% for adults and 98% for children. Per capita spending reflects the full-scope Medicaid average cost in the state of interest.

Medicaid-like coverage to noncitizens ages 65 and older regardless of their immigration statuses (KFF 2025a). This expansion was part of Governor Pritzker’s broader health care agenda and was supported by Democratic lawmakers. Then, in 2022 Illinois expanded the Health Benefits for Immigrant Adults (HBIA) program, initially covering noncitizens ages 55 to 64 and later expanding to cover those ages 42 and older. Notably, HBIS and HBIA enrollees may be eligible for kidney transplants or bone marrow transplants, and emergency Medicaid covers renal dialysis (Broder 2025).

The state’s expansion of health care access to immigrants was driven by a favorable political environment and several diffusion mechanisms. A key factor was learning from California’s health care programs. Illinois adapted these programs to its unique demographic, particularly the large urban immigrant population in Chicago, by designing benefits that would address

specific health care needs, such as organ transplants. Local financial assistance programs, such as Cook County's Care Link, were also modeled after other local programs in California to provide direct health care access to uninsured adults through a medical home model. The expansion was also shaped by pressure in the form of strong legal advocacy from immigrant and health care rights groups, such as the Illinois Coalition for Immigrant and Refugee Rights and the Illinois Legislative Latino Caucus, which pressured state policy makers to provide more comprehensive health care options for noncitizens (Paral 2004). These advocacy efforts highlighted the disparities in health care access and the need for equitable policy responses, prompting the state to gradually extend coverage.

Despite the rapid expansion of HBIS and HBIA in Illinois, the cost of these programs far exceeded initial estimates, which led to policy adjustments. By 2023, the state had to suspend new enrollments for adults younger than 65 in the HBIA program, and proposed terminations were included in the 2026 budget (HFS 2025). Coverage for immigrants remains uncertain, as anticipated federal Medicaid cuts in 2025 could significantly reduce funding. With Illinois lacking the fiscal capacity to offset these reductions, coverage may not be sustainable. In 2025, approximately 62% of Illinois' Medicaid spending was funded by the federal government, with the remaining 38% covered by the state (Hancock, Aubrey, and UIS PAR 2025). These fiscal challenges highlight the difficulty of sustaining expansive immigrant health programs without federal support. Nonetheless, the state's government remains committed to these expansions, despite budgetary pressures.

Expansionary health policies for noncitizens were supported by parallel policies that made it easier for noncitizens to live and work in the state, such as in-state tuition and financial aid for undocumented students, driver's licenses regardless of status, and labor protections that apply to all workers. Illinois also limits local law enforcement cooperation with federal immigration authorities and funds legal aid programs in some jurisdictions (IITF 2023). According to the policy context framework, Illinois is a high integration, low criminalization state, which means Illinois has many policies that expand rights and access to resources for immigrants while having few policies that increase their risk of immigration enforcement. This creates an environment of proactive inclusion, where noncitizens are protected from deportation and actively included (Young and Wallace 2019). The evolving nature of Illinois's immigrant health care programs shows a balance between expansionary health programs for noncitizens, economic constraints, and advocacy-driven efforts for greater inclusivity.

From 2008 to 2023, the share of noncitizen immigrants with health insurance in Illinois increased significantly, from 55.2% to 72.1%, while Medicaid coverage also grew substantially, rising from 8.3% to 17.2% (table 1). These improvements were accompanied by higher educational attainment, increased income, and greater English proficiency (table 1). When these factors are considered, the marginal effects models showed significant increases in the likelihood of having health insurance from 2014 onward, with the highest increase observed in 2023 (fig. 1, table 2). Similarly, the likelihood of having Medicaid for noncitizen immigrants with household incomes below 200% of the federal poverty level increased significantly, particularly from 2010 onward, with the highest increase in 2023 (fig. 2, table 3). In 2022, Illinois had an estimated undocumented immigrant population of 408,000, with 48.9% uninsured. Predicted Medicaid enrollment in 2022 for income-eligible uninsured undocumented immigrants and lawfully present immigrants with fewer than five years of US residence ranged from 79,000 to 99,200, with average state spending per enrollee of \$7,100 (table 4).

Texas

Texas has a long history of prioritizing limited government and resisting federal programs and regulations, rooted in its political culture of individual rights and local control. Since the mid-1990s, the Republican Party has dominated state politics and has shaped the state's approach to health care by rejecting federal programs like Medicaid (Bitler and Hoynes 2011). In 2002, the state expanded Medicaid and CHIP eligibility to lawfully residing immigrant children and offered prenatal care through CHIP regardless of immigration status (Young and Wallace 2019). Despite the availability of substantial federal funds to expand Medicaid eligibility under the ACA, Texas opted not to expand the program because of opposition to increased spending and federal involvement. The state's political coalitions, which are shaped by conservative priorities and restrictive views on immigration, have driven policies that exclude immigrants from accessing Medicaid and reflect broader efforts to limit public benefits and access to services.

As a result, immigrants in the state are only eligible for emergency care through Medicaid and lack access to broader coverage (KFF 2025a). Texas's limited safety net programs further reinforce this gap, as the state relies heavily on charity organizations and local governments to provide health services and support to noncitizen adults. This reliance on local

governments shifts the burden to local safety nets, particularly in areas with high immigrant populations.

The diffusion of these restrictive policies can be understood through different mechanisms. First, Texas has often set the agenda for other conservative states that limit public benefits and health care access for noncitizens. In 2024, the state passed legislation requiring hospitals receiving Medicaid or CHIP funding to ask patients about their immigration status when seeking inpatient and emergency care (AP 2024). This policy was soon adopted by other conservative states such as Florida in 2025 (Marchante 2023). This imitation by neighboring states reflects a broader ideological commitment to expanding state involvement in monitoring and regulating access to health and public programs. Additionally, competition plays a key role in shaping Texas's approach, as the state seeks to avoid policies that might attract an influx of migrants, particularly from neighboring states. For example, Texas invested \$11 billion on border enforcement through initiatives like Operation Lone Star and has taken high-profile actions such as busing migrants to other states, which signals an effort to shift the perceived burden of migration (Torres 2024). These strategies reflect a broader attempt to manage state resources while reinforcing a political position aimed at discouraging migrants presumed to be attracted by generous public services.

Texas has also led state efforts to support federal policies that restrict access to Medicaid among noncitizens. For example, in 2023 Texas led a lawsuit against the federal government challenging the Biden administration's repeal of Trump-era changes to the "public charge" rule, which included Medicaid receipt as a potential reason to deny a visa or permanent residence to noncitizens (Wiessner 2024). Texas' resistance to coercion in implementing such policies is reflected in its defense of restrictive measures against legal challenges and efforts to preempt proimmigrant policies, such as sanctuary policies limiting law enforcement collaboration with immigration authorities (Hall, Mann-Jackson, and Rhodes 2021).

The restrictive health policy environment in Texas is further amplified by criminalizing policies targeting noncitizens. According to the policy context framework, Texas is characterized by high integration and high criminalization. While some policies promote access to resources such as prenatal health care and children's health insurance, noncitizens in Texas are also subject to potential surveillance and increased collaboration with federal immigration enforcement, which creates a context of deportable inclusion (Young and Wallace 2019). Despite multiple lawsuits challenging these policies, Texas has largely maintained its restrictive stance,

reflecting a political coalition that supports conservative priorities in immigration and social policy.

Despite this restrictive policy environment, from 2008 to 2023 the share of noncitizen immigrants with health insurance in Texas increased significantly, from 37.9% to 52.9%. Medicaid coverage also grew slightly, rising from 6.9% to 8.1% (table 1). These improvements were accompanied by higher educational attainment, increased income, and greater English proficiency (table 1). When these factors were considered, the marginal effects models show significant increases in the likelihood of having any health insurance from 2014 onward, with the highest increase observed in 2023 (fig. 1, table 2). Similarly, the likelihood of having Medicaid for noncitizens with household incomes below 200% of the federal poverty level increased significantly, especially from 2010 onward, with the highest increase in 2023 (fig. 2, table 3). Texas has an undocumented immigrant population of 1.8 million, with 66.5% uninsured. Predicted Medicaid enrollment in 2022 for income-eligible uninsured undocumented immigrants and lawfully present immigrants with fewer than five years of US residence ranged from 312,500 to 391,300, with an average state spending per enrollee of \$5,300 (table 4).

Georgia

Unlike California, Illinois, and Texas, which have long been immigrant gateways, Georgia has only experienced a high inflow of noncitizen immigrants in the last couple of decades (Vargas Bustamante 2024). Like Texas, Georgia is a conservative state that has maintained a restrictive stance on public health programs, particularly for noncitizens. Georgia's political environment has been shaped by a blend of conservative values and a focus on fiscal conservatism, which has influenced the state's approach to health care coverage and particularly Medicaid. Even when Democrats held power in the 1990s, the state chose not to expand Medicaid, mainly because of concerns about long-term costs and the reluctance to accept federal control over state programs (Chan 2023). As the political landscape shifted toward Republican leadership, the state's opposition to Medicaid expansion strengthened even more. The state chose not to expand Medicaid eligibility under the ACA, limiting immigrants' access to emergency services only (KFF 2025b). Additionally, Georgia's safety net programs are minimal, with limited resources for low-income individuals, particularly noncitizens. In 2016, the state passed laws that further restricted undocumented immigrants' access to public services, making it even more difficult for them to receive assistance (Kline 2019). Previous research has partly

attributed these policies to the lack of a strong network of advocates and community organizations that support noncitizens in other states with a longer history of immigrant settlements.

The diffusion of these restrictive policies in Georgia can be understood through imitation and resistance to coercion. Like Texas and other Republican-led states, Georgia has adopted conservative policies that limit public programs and health care services for noncitizens (Heyison and Gonzales 2024). This imitation reflects a regional trend of similar policies to maintain control over immigration, health, and social services. Georgia was part of a bloc of Southern states, which included Texas, Florida, Alabama, Mississippi, South Carolina, and Tennessee, that have refused to expand Medicaid under the ACA (KFF 2025c). Targeted state laws that increased barriers to health care, particularly for undocumented immigrants, was a trend that emerged in the 2010s in Republican-led states such as Georgia, Alabama, and Arizona (Kline 2019). In addition, Georgia resisted initial federal coercion, but after the US Supreme Court made the Medicaid expansion voluntary for states in 2012, Georgia policy makers continued their position by rejecting incentives to expand Medicaid. This refusal highlights the state's commitment to conservative politics, prioritizing limiting government spending and resisting federal involvement in public health policies.

The policy context in Georgia is characterized by low integration and high criminalization. Georgia exemplifies enhanced deportability, where noncitizens face the risk of increased surveillance, policing, and deportation, along with limited access to rights and opportunities (Young and Wallace 2019). Criminalizing policies even extend to health care providers offering services to noncitizens. For example, Georgia's HB 87, passed in 2011, included provisions that criminalized transporting or harboring undocumented immigrants, raising concerns among health care and social service providers about potential legal risks (Kline 2019). Although many of these policies were eventually struck down by state and federal courts, they have created an environment of fear and mistrust within immigrant communities. Georgia has also experimented with Medicaid work requirements, further limiting access to health services for low-income individuals by imposing employment-related conditions on Medicaid eligibility (Broder 2025).

Despite this policy context, from 2008 to 2023 the share of noncitizen immigrants with health insurance in Georgia increased significantly, from 40.1% to 57.3%. Medicaid coverage also grew modestly, rising from 2.9% to 6.4% (table 1). These improvements were accompanied by higher educational attainment, increased income, and greater English proficiency

(table 1). When these factors were considered, the marginal effects models showed significant increases in the likelihood of having any health insurance from 2014 onward, with the highest increase observed in 2023 (fig. 1, table 2). Similarly, the likelihood of having Medicaid for noncitizens with household income below 200% of the federal poverty level increased significantly, especially from 2010 onward, with the highest increase in 2023 (fig. 2, table 3). Georgia has an undocumented immigrant population of 335,000, with 64.5% uninsured. Predicted Medicaid enrollment in 2022 for income-eligible uninsured undocumented immigrants and lawfully present immigrants with fewer than five years of US residence ranged from 44,700 to 56,000, with average state spending per enrollee of \$7,200 (table 4).

Discussion

The findings of this study highlight the complex and divergent policy trajectories that states have taken in response to PRWORA's restrictions on immigrant health coverage. The case studies of California, Illinois, Texas, and Georgia show how state-level partisan politics, ideologies, and advocacy efforts have combined with external factors to shape state policy decisions about noncitizen health coverage. By applying the policy diffusion and policy context frameworks, this study emphasizes the role of policy learning, imitation, competition, and coercion and pressure in shaping state health policies for noncitizen immigrants.

These divergent policy approaches have implications for noncitizen health outcomes and broader public health systems. States that have expanded coverage for noncitizens show lower uninsured rates and higher Medicaid enrollment, while restrictive states face higher levels of uninsurance, leading to more uncompensated care costs, greater reliance on emergency medical services, and increased health disparities (Altman, Hamilton, and Dondero 2023). One of the most important findings of this study is that from 2008 to 2023, insurance coverage and Medicaid enrollment of noncitizens increased across California, Illinois, Texas, and Georgia, which have very different political and policy contexts. While California and Illinois had the most substantial improvements and expanded access directly through state-funded programs, Texas and Georgia experienced small gains (table 1). These gains occurred in parallel with demographic and socioeconomic changes among noncitizens in the four states, including higher educational attainment, increased income, and greater English proficiency, that could have contributed to increased insurance and Medicaid enrollment (table 1). In 2023, noncitizens in the four states were older and less likely to be Latino compared to

2008, which reflects national trends and perhaps a greater need to seek insurance and Medicaid coverage (Vargas Bustamante et al. 2021).

The influence of federal policy design as part of ACA implementation could have reshaped state outcomes, even in states that did not expand Medicaid, by creating new coverage pathways and lowering access barriers for eligible noncitizens. The marginal effects models further highlight these trends and show significant increases in the likelihood of having any health insurance and Medicaid coverage from 2014 and 2010 onward (tables 2 and 3; figs. 1 and 2). Increased Medicaid enrollment in the four states after 2010, and especially after 2014, is likely the result of increased funding from the ACA and various waivers that allowed states to innovate in providing Medicaid benefits (KFF 2025b). While political ideology and state-level decision-making drove differences in how states approached noncitizen health care access, this period also coincided with federal health care innovations that could have been reflected in increased insurance and Medicaid coverage, even in states that rejected formal Medicaid expansion. Section 1115 waivers gave states new tools to innovate with limited expansions or redefine eligibility groups. Administrative simplifications, such as streamlined enrollment procedures and express lane eligibility, increased overall Medicaid participation, including among eligible noncitizens in mixed-status families (KFF 2025b).

Our study shows important differences in the size of undocumented immigrant populations and rates of being uninsured across states. Predicted Medicaid enrollment varies, with California expecting the highest enrollment and Georgia the lowest (table 4). Interestingly, the average predicted state spending per enrollee is highest in California and Georgia, and lowest in Texas, which is likely because of differences in health care market prices (table 4). These differences highlight the varying trade-offs and financial implications each state faces in providing health care coverage to immigrants affected by PRWORA exclusions. These findings suggest that policy fragmentation at the state level perpetuates inequalities in access to health care and reinforces stratification based on legal status and geographic location.

Policy Implications

The findings of this study suggest that future state and federal policies on immigrant health care access will be shaped by legal frameworks and political dynamics, especially during the second Trump administration. PRWORA will likely serve as a foundation for increasingly restrictive federal policies that may further limit noncitizen eligibility for public health programs.

At the state level, policy changes could be influenced by a combination of federal incentives, advocacy efforts, and external crises. States that have historically resisted expanding health coverage for immigrants may be influenced by federal financial incentives, such as Medicaid expansion funds, which have previously prompted adoption in some restrictive states. Federal Medicaid funding proposals, such as block grants, per capita payments, or mandatory work requirements, could worsen the fiscal challenges for progressive states that have expanded state-funded coverage to noncitizens. State-level advocacy groups will continue to play a critical role in shaping health care policies, particularly in states where policy makers remain undecided or open to reform. Legal challenges and unforeseen public health crises, such as the COVID-19 pandemic, may also force policy shifts in states that have resisted expanding access.

If current policy trends continue, mass deportations and other measures to deter immigration, such as potential restrictions on birthright citizenship, could significantly reduce health care access for noncitizens (Félix Beltrán et al. 2025). A decrease in immigrant inflow would also have economic consequences by reducing payroll tax contributions to Medicare, Social Security, and federal tax revenues. Meanwhile, the aging noncitizen population is increasing, which is leading to a growing demand for expanded health coverage. However, because of existing restrictions, many older immigrants will remain ineligible for Medicare and other public programs, exacerbating disparities in health care access.

Chilling effects from restrictive immigration policies will likely discourage US-born children in mixed-status households from enrolling in public programs, even when they are eligible (Vargas Bustamante et al. 2022). This could lead to higher uninsured rates among children and worsen long-term health and economic outcomes for immigrant families (Perreira and Pedroza 2019). Policy makers must consider these broader implications when designing health care policies for immigrant populations. Without interventions to prioritize coverage expansion and mitigate the chilling effects of restrictive policies, disparities in health care access will persist, with significant consequences for both immigrant communities and the broader public health system.

Conclusion

As the United States approaches the 30th anniversary of PRWORA, the evolution of state policies on immigrant health coverage remains a critical issue for policy makers, advocates, and researchers. This study's findings emphasize the need for continued analyses of the long-term effects of these

policies and the potential for future policy changes. Expanding insurance coverage for noncitizens not only addresses health inequities but also supports broader public health and economic stability. Moving forward, it is essential to assess the sustainability of expansionary programs, the political feasibility of additional reforms, and the role of federal-state dynamics in shaping immigrant health care access.

Federal policy changes and demographic shifts will continue to shape state-level approaches to immigrant health care. As the political landscape changes with Donald Trump's return to the White House, potential federal restrictions, such as limitations on birthright citizenship or increased immigration enforcement, could have profound chilling effects on immigrant communities and may deter eligible individuals from accessing health care services. Meanwhile, the aging immigrant population and their ineligibility for Medicare underscore the need for more inclusive policies to address long-term health care challenges. Over the past two decades, despite growing variation in state policy environments, noncitizens had significant gains in health insurance coverage, largely a result of the positive spillover effects of the ACA. Whether these gains will continue amid rising anti-immigrant rhetoric and federal policies remains uncertain.

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Acknowledgments

This article was supported by the National Institute on Minority Health and Health Disparities of the National Institutes of Health under award number R01MD018727. The content is solely the responsibility of the authors and does not necessarily represent the official views of the National Institutes of Health. Arturo Vargas Bustamante wants to acknowledge Ahmad Ismail for research support.

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