ISSUE BRIEF
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Immigrant Women's Access to Sexual and Reproductive Health Coverage and Care in the United States

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ABSTRACT

ISSUE: Immigrant women of reproductive age in the U.S. face significant challenges obtaining comprehensive and affordable health insurance coverage and care — including sexual and reproductive health services — compared with U.S.-born women, because of myriad policy and systemic factors.

GOALS: Synthesize recent evidence on immigrant women's access to sexual and reproductive health coverage and care and provide recommendations for policymaking and research.

METHODS: A rapid literature review to identify and summarize evidence from peer-reviewed and select grey literature published since 2011 on health insurance coverage and sexual and reproductive health care services use among immigrant women in the U.S. Where available, evidence is compared to U.S.-born women.

FINDINGS AND CONCLUSIONS: Immigrant women are less likely to have coverage and use sexual and reproductive health services than U.S.-born women, which may increase their risk of negative outcomes. Federal and state policymakers could take actions to advance immigrant women's sexual and reproductive health, including expanding eligibility for coverage and shoring up the nation's health care safety net. Further research is needed to understand the needs, use of services, and outcomes of immigrant women, as well as the factors that contribute to differences between immigrant and U.S.-born women, and among groups of immigrant women.

TOPLINES

- **In the U.S., a smaller proportion of immigrant women — including both undocumented and those lawfully present — have health insurance coverage and are less likely to use sexual and reproductive health services, compared with U.S.-born women.**
- **Among immigrant women who do obtain contraceptive care, they are significantly more likely than their U.S.-born counterparts to visit publicly funded family planning centers.**

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INTRODUCTION

Access to a full range of sexual and reproductive health services is critical to the well-being of individuals, families, and communities. Contraceptive use helps women realize their own reproductive goals, which in turn helps them achieve their educational, employment, and financial ambitions.[1] For pregnant women, information about and access to a full range of options are also key to realizing health and life goals.[2] Preventive services, such as STI testing and reproductive cancer screening, help prevent negative outcomes including pelvic inflammatory disease, adverse pregnancy and birth outcomes, and cervical cancer and related mortality.[3] Comprehensive insurance coverage of these services helps make them affordable and accessible.[4]

But millions of women face structural barriers to obtaining such coverage and care, based solely on their immigration status. This includes women who are lawfully present and those who are undocumented. When immigrant women — nearly half of whom are of reproductive age (15–44)[5] — are unable to obtain basic care, their health, well-being, and economic security are jeopardized, as well as the well-being and stability of their families and communities. Indeed, numerous policies and protocols effectively block many immigrants from affordable health insurance coverage, including programs their tax dollars support, and degrade immigrants' considerable contributions to their communities and the nation's economy. Many lawfully present immigrants are ineligible to enroll in coverage through Medicaid and the Children's Health Insurance Program (CHIP) during their first five years of legal residency, while undocumented immigrants are largely barred from public coverage overall. Although some states have made limited exceptions to the "five-year bar" for pregnant women and those age 18 and younger (Exhibit 1),[6] barriers to coverage persist for many immigrants.

Although most lawfully present immigrants are eligible to purchase private coverage through the Affordable Care Act's (ACA) health insurance marketplaces using premium tax credits and cost-sharing subsidies, undocumented immigrants are entirely barred from marketplace coverage. Moreover, policymakers' recent attempts to destabilize the ACA's marketplaces — which have helped many people access a wide range of services and providers — would have considerable implications for sexual and reproductive health, if implemented.[7]

U.S. immigration policy also affects immigrants' access to coverage and care. For instance, the Deferred Action for Childhood Arrivals (DACA) Program established in 2012 enables grantees — all of whom are of reproductive age — to lawfully remain in the country. But despite their lawful status, individuals granted DACA are barred from nearly all public coverage, ACA marketplace plans, and affordability programs. Their years in the U.S. do not count toward their five-year path to Medicaid eligibility.

Recent attempts to repeal DACA, in addition to increasingly strict enforcement of immigration policies, have heightened fear and distress among immigrants, likely impeding their access to coverage and care.[8] In addition, the current administration has proposed sweeping changes to the so-called public charge test, which has been part of federal immigration law for decades, and has been used to determine whether individuals may rely on public programs as a main source of financial support. The administration's proposed regulatory changes would dramatically limit people's ability to enter the country or obtain a green card based on their use of public programs, including Medicaid.[9] These changes are widely expected to decrease enrollment in and use of these programs among eligible individuals because of fear of punitive action, with pronounced ramifications for pregnant or postpartum women and children.[10]

The evidence synthesized below (based on a rapid literature review[11]) compares the experiences of immigrant women to those of women born in the United States, resulting in recommendations for further research and policymaking.

Exhibit 1. Limited Exceptions to the Five-Year Bar

State	Lawfully residing immigrant children without 5-year wait (Medicaid or CHIP)	Lawfully residing pregnant women without 5-year wait (Medicaid or CHIP)	Pregnant women regardless of status (CHIP)
Alabama			
Alaska			
Arizona			
Arkansas	●	●	●
California	●	●	●
Colorado	●	●	
Connecticut	●	●	
Delaware	●	●	
District of Columbia	●	●	
Florida	●		
Georgia			
Hawaii	●	●	
Idaho			
Illinois	●		●
Indiana			
Iowa	●		
Kansas			
Kentucky	●		
Louisiana			●
Maine	●	●	
Maryland	●	●	
Massachusetts	●	●	●
Michigan			●
Minnesota	●	●	●
Mississippi			
Missouri			●
Montana	●		
Nebraska	●	●	●
Nevada	●		
New Hampshire			
New Jersey	●	●	
New Mexico	●	●	
New York	●	●	
North Carolina	●	●	
North Dakota			
Ohio	●	●	
Oklahoma			●
Oregon	●		●
Pennsylvania	●	●	
Rhode Island	●		●
South Carolina	●	●	
South Dakota			
Tennessee			●
Texas	●		●
Utah	●		
Vermont	●	●	
Virginia	●	●	
Washington	●	●	●
West Virginia	●	●	
Wisconsin	●	●	●
Wyoming		●	
U.S. total	34	25	16

Data: Kaiser Family Foundation and National Immigration Law Center.

Notes: States can use Medicaid and CHIP funds to cover lawfully residing children and pregnant women, regardless of their date of entry, and can use CHIP funds to cover prenatal care, labor and delivery for a pregnant woman, regardless of immigration status, by covering her fetus. Coverage policies are as of January 2018.

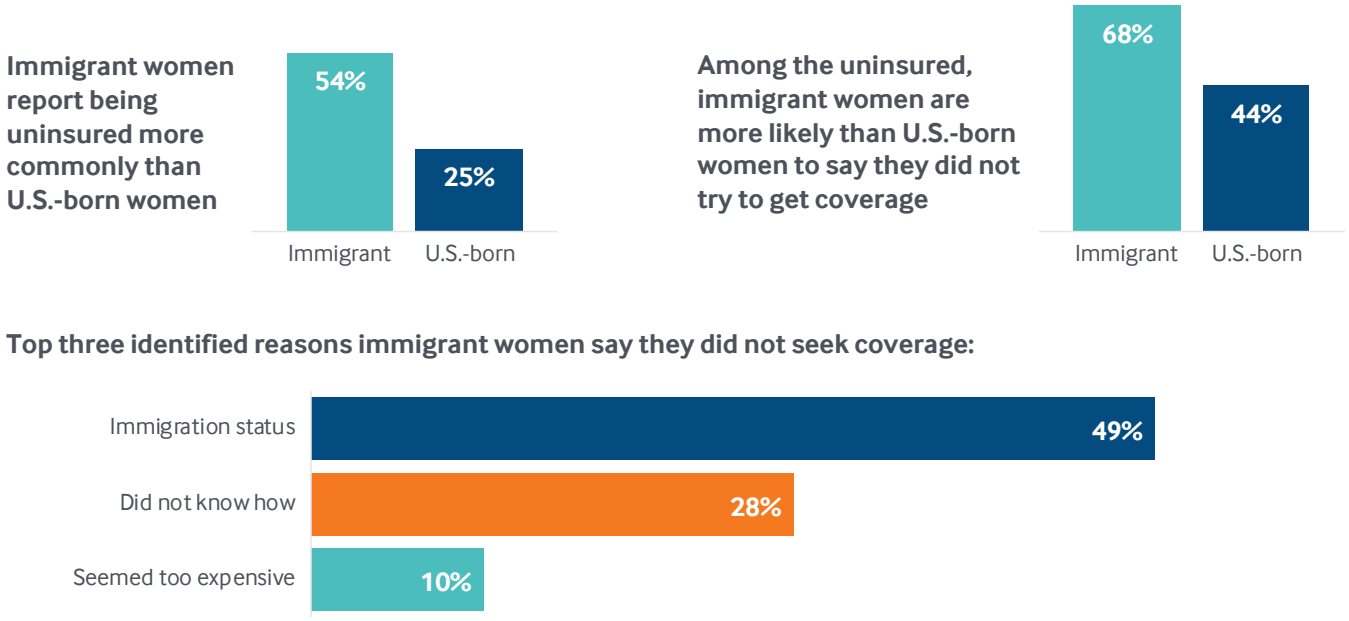
FINDINGS

Although limited, existing research suggests immigration status influences women's sexual and reproductive health coverage, care, and outcomes. Some evidence indicates that immigration status may serve as a protective factor in specific instances: some immigrant groups may have a lower risk of breast cancer and HIV, and immigrant women overall are less likely to report unplanned or preterm births compared to U.S.-born women.[12] However, other studies indicate immigrant women may be at heightened risk for some pregnancy- and birth-related complications, such as gestational diabetes and cesarean delivery.[13] Indeed, the majority of evidence indicates that being an immigrant in the U.S. is associated with obstacles to obtaining coverage and sexual and reproductive health services. Although immigrants in the U.S. are not a homogenous group, most national-level research does not examine this population by different demographic groups. Thus this paper largely reflects the overall immigrant population.

Differences in Obtaining and Using Coverage Between Immigrant and U.S.-Born Women

As suggested, policy barriers have contributed to gaps in immigrant women's health coverage. In 2016, 34 percent of the 6.4 million noncitizen immigrant women of reproductive age were uninsured, compared to 9 percent of U.S.-born women.[14] A nationally representative Guttmacher study of women obtaining contraception at Title X–funded health centers in 2016 found that, compared to U.S.-born patients, immigrant patients were significantly more likely to report not seeking or having insurance coverage (Exhibit 2).[15] About one of five immigrant patients who had coverage did not plan to use it; the study authors suggest some of these patients may have experienced real or perceived threats because of their immigration status while others may have faced language and other logistical barriers.

Exhibit 2. Disparities in Health Coverage Between Immigrant and U.S.-Born Women Obtaining Care at Title X–Funded Sites



Data: Guttmacher Institute.

Note: Data come from a nationally representative sample of women age 15 and older receiving contraceptive services at Title X–funded sites in 2016.

Differences in Use of Services Between Immigrant and U.S.-Born Women

Overall, a smaller proportion of immigrant women of reproductive age use sexual and reproductive health services, particularly when it comes to contraceptive care for those at risk of unintended pregnancy.[16] One Guttmacher study found that only half of immigrant women had received contraceptive services or information in the previous year, compared to two-thirds of U.S.-born women.[17] Another study found that immigrant women are less likely to have used a contraceptive method deemed "highly effective" at preventing pregnancy (e.g., IUDs and implants), with variations by race and ethnicity.[18] These trends may be driven in part by individual women's contraceptive needs and preferences, high up-front costs, and required placement by a clinician.

Evidence also suggests immigrant women are less likely to receive other preventive services, such as Pap tests to detect and prevent cervical cancer and screening and vaccinations for hepatitis B, which can be life-threatening for infants.[19] Immigrant women, particularly those who are uninsured and noncitizens, are also significantly less likely to obtain mammograms.[20]

Importance of Safety-Net Providers

Among those who do obtain services, immigrant women are significantly more likely than U.S.-born women to obtain services from publicly funded family planning centers.[21] For example, 41 percent of immigrant women who obtained contraceptive care in the years 2006 to 2010 did so at safety-net family planning centers, compared to 25 percent of their U.S.-born counterparts. Seven of 10 immigrant women reported a safety-net site as their usual source of medical care.[22] These findings underscore the importance of these providers for low-income and uninsured immigrants.

AREAS FOR FUTURE RESEARCH

We need additional studies to better understand differences between immigrant and U.S.-born women's sexual and reproductive health. For instance, though immigrant and U.S.-born women use abortion services at comparable rates,[23] there is no research on the characteristics of immigrant women who seek abortion services or the barriers they face. Exploring how individual and contextual factors influence immigrant women's sexual and reproductive health experiences, decisions, and outcomes could inform policies and protocols that would improve their ability to obtain services, as well as their well-being.

Improved study methods, such as oversampling or pooling data on underrepresented immigrants, also are needed to enhance research in this area. Data collection and analysis methods that disaggregate populations by characteristics such as country or region of origin, or length of stay in the U.S., will be key to identifying critical differences within this increasingly diverse population. Research efforts also can better reach and represent immigrant groups, by developing data collection tools in multiple languages and engaging immigrant communities and advocacy organizations as valued partners.

It is also important to identify and understand the impact of immigration-related policies on health care access and use. Some studies have found negative health consequences for immigrants experiencing detention, deportation, or the threat of such action, requiring further investigation, including on sexual and reproductive health indicators.[24]

POLICY OPTIONS

Advancing immigrant women's sexual and reproductive health and the well-being of families and communities requires action from policymakers. For instance, publicly funded family planning providers are increasingly under threat by efforts to limit the reach of Medicaid and attempts to fundamentally alter the Title X program. Funding and protecting the integrity of these programs is necessary to sustain safety-net providers' ability to effectively serve their patients.[25] Policymakers also can support community health worker models, which serve as a bridge between underserved communities and the health care system through community-level care coordination, and have long been essential to the nation's safety net.[26]

At the federal level, policymakers can maintain the ACA's advances, particularly for immigrants eligible for marketplace plans that cover contraceptive and other preventive services without additional cost-sharing, as well as comprehensive maternity services.[27] Moreover, Congress can lift the five-year bar on Medicaid and CHIP and the administration can allow DACA recipients to participate in the ACA's affordable coverage options and in Medicaid and CHIP, where eligible. Such expansions would contribute to better health outcomes, reduce out-of-pocket costs for low-income immigrant women and their families, and enhance safety-net providers' sustainability.[28]

At the state level, policymakers that have not adopted all federally supported coverage expansions specific to immigrant women who are pregnant and immigrant children can do so. States also can invest their own funds into programs that make coverage and care more accessible to immigrants, including undocumented immigrants; many have already done so, and others could follow suit.[29]

Finally, immigrants in the U.S. face policies and practices that can deter them from obtaining or using coverage and seeking necessary health services.[30] Advancing immigrant women's sexual and reproductive health will necessitate action beyond the health sector, including reforming federal and state immigration policies to better recognize and promote the health and rights of all individuals.[31]

HOW WE CONDUCTED THIS STUDY

We conducted a rapid literature review to identify peer-reviewed publications and select grey literature that document insurance coverage, behaviors, and outcomes related to the sexual and reproductive health of immigrant women in the U.S. (A rapid literature review is "a form of evidence synthesis that may provide more timely information for decision making compared with standard systematic reviews."[32]) This approach synthesizes key concepts, knowledge gaps, and types of evidence, and is particularly useful when compiling timely information within an evolving field of research. Like a systematic review, inclusion and exclusion criteria guide the parameters of the review.

Parameters for inclusion were:

a. quantitative research on coverage, behaviors, and/or outcomes related to the sexual and reproductive health of immigrant women (individuals born outside the U.S.) living in the United States. Components of sexual and reproductive health include access to and use of contraception, abortion, obstetric and gynecologic services, and maternal health care; sexual activity and behaviors; outcomes related to sexually transmitted and reproductive tract infections and cancers; and reproductive freedom;

b. peer-reviewed research and published reports from the Guttmacher Institute, Commonwealth Fund, Henry J. Kaiser Family Foundation, Migration Policy Institute, and the Center on Budget and Policy Priorities; and

c. data published from 2011 onward.

To identify relevant peer-reviewed articles, we searched PubMed and GoogleScholar using the following terms, alone and in combination: women, immigrant, foreign-born AND reproductive health, sexual health, insurance, coverage, disparities, sexual activity, maternal health, contraception, family planning, abortion, sexually transmitted infections, reproductive tract infections, reproductive cancer, and unintended pregnancy. Grey literature such as published reports and issue briefs were identified through organizational websites. Relevant references in key reports and journal articles also were reviewed for inclusion. For each report or article that met the inclusion criteria, we identified the topical area of focus and summarized relevant and robust findings for inclusion in the brief.

We identified 24 publications in this review that spanned three areas related to sexual and reproductive health: health insurance coverage, health service use, and health outcomes. Among the 24 publications, 17 were peer-reviewed articles published in public health or social science journals and seven were advocacy briefs, fact sheets, and issue reports published by the aforementioned organizations.

NOTES

1. Adam Sonfield, "What Women Already Know: Documenting the Social and Economic Benefits of Family Planning," *Guttmacher Policy Review* 16, no. 1 (Spring 2013).

2. Kinsey Hasstedt, "Unbiased Information on and Referral for All Pregnancy Options Are Essential to Informed Consent in Reproductive Health Care," *Guttmacher Policy Review* 21 (2018).

3. Kinsey Hasstedt, "More Than a Pack of Pills: The Many Components and Health Benefits of Quality Family Planning," *Guttmacher Policy Review* 17, no. 3 (Summer 2014).

4. Henry J. Kaiser Family Foundation, *Women's Health Insurance Coverage*, fact sheet (KFF, Oct. 2017).

5. Migration Policy Institute, *Age-Sex Pyramids of U.S. Immigrant and Native-Born Populations, 1970-Present* (MPI, n.d.).

6. Tricia Brooks et al., *Medicaid and CHIP Eligibility, Enrollment, Renewal, and Cost Sharing Policies as of January 2018: Findings from a 50-State Survey* (Henry J. Kaiser Family Foundation, Mar. 2018); and National Immigration Law Center, "Health Care Coverage Maps" (NILC, revised Aug. 13, 2018).

7. Kinsey Hasstedt, "How Dismantling the ACA's Marketplace Coverage Would Impact Sexual and Reproductive Health," *Guttmacher Policy Review* 20 (published online Apr. 6, 2017).

8. Samantha Artiga and Petry Ubri, *Living in an Immigrant Family in America: How Fear and Toxic Stress Are Affecting Daily Life, Well-Being, and Health* (Henry J. Kaiser Family Foundation, Dec. 2017); Edward D. Vargas, Gabriel R. Sanchez, and Melina Juárez, "Fear by Association: Perceptions of Anti-Immigrant Policy and Health Outcomes," *Journal of Health Politics, Policy and Law* 42, no. 3 (June 2017): 459–83; and Morgan M. Philbin et al., "State-Level Immigration and Immigrant-Focused Policies as Drivers of Latino Health Disparities in the United States," *Social Science & Medicine* 199 (Feb. 2018): 29–38.

9. Krista M. Perreira, Hirokazu Yoshikawa, and Jonathan Oberlander, "A New Threat to Immigrants' Health — The Public-Charge Rule," *New England Journal of Medicine* 379, no. 10 (Sept. 6, 2018): 901–3.

10. Sharon Parrott, Shelby Gonzales, and Liz Schott, *Trump 'Public Charge' Rule Would Prove Particularly Harsh for Pregnant Women and Children* (Center on Budget and Policy Priorities, May 2018).

11. A rapid literature review is "a form of evidence synthesis that may provide more timely information for decision making compared with standard systematic reviews." See: Lisa Hartling et al., *EPC Methods: AHRQ End-User Perspectives of Rapid Reviews* (Agency for Healthcare Research and Quality, Apr. 2016).

12. Karen M. Coller et al., "Unintended Births Among Adult Immigrant and U.S.-Born Mexican Women in the Los Angeles Mommy and Baby (LAMB) Survey," *Women's Health Issues* 24, no. 4 (July–Aug. 2014): e365–e372; Denise Vasquez et al., "Unintended Birth Among Hispanic Women in Texas: A Descriptive Analysis," *Maternal and Child Health Journal* 19, no. 6 (June 2015): 1220–29; Scarlett Lin Gomez et al., "Hidden Breast Cancer Disparities in Asian Women: Disaggregating Incidence Rates by Ethnicity and Migrant Status," *American Journal of Public Health* 100, no. S1 (Apr. 2010): S125–S131; and Gopal K. Singh, Alfonso Rodriguez-Lainz, and Michael D. Kogan, "Immigrant Health Inequalities in the United States: Use of Eight Major National Data Systems," *Scientific World Journal* (2013), article ID 512313.

13. Teresa Janevic et al., "The Role of Obesity in the Risk of Gestational Diabetes Among Immigrant and U.S.-Born Women in New York City," *Annals of Epidemiology* 28, no. 4 (Apr. 2018): 242–48; and Teresa Janevic et al., "Disparities in Cesarean Delivery by Ethnicity and Nativity in New York City," *Maternal and Child Health Journal* 18, no. 1 (Jan. 2014): 250–57.

14. Guttmacher Institute, *Dramatic Gains in Insurance Coverage for Women of Reproductive Age Are Now in Jeopardy* (Guttmacher, Jan. 2018).

15. The Title X national family planning program is the sole federal program dedicated to helping individuals obtain high-quality, affordable family planning services in the United States. See: Kinsey Hasstedt, "Why We Cannot Afford to Undercut the Title X National Family Planning Program," *Guttmacher Policy Review* 20 (Jan. 30, 2017); and Megan L. Kavanaugh, Mia R. Zolna, and Kristen Burke, "Use of Health Insurance Among Clients Seeking Contraceptive Services at Title X–Funded Facilities in 2016," *Perspectives on Sexual and Reproductive Health* 50, no. 3 (Sept. 2018): 101–09.

16. Athena Tapales, Ayana Douglas-Hall, and Hannah Whitehead, *The Sexual and Reproductive Health of Foreign-Born Women in the United States* (Guttmacher Institute, Feb. 2018); Ellen K. Wilson, "Difference in Contraceptive Use Across Generations of Migration Among Women of Mexican Origin," *Maternal and Child Health Journal* 13, no. 5 (Sept. 2009): 641–51.

17. Jennifer J. Frost, *U.S. Women's Use of Sexual and Reproductive Health Services: Trends, Sources of Care and Factors Associated with Use, 1995–2010* (Guttmacher Institute, May 2013).

18. Tapales, Douglas-Hall, and Whitehead, "Sexual and Reproductive Health," 2018.

19. Sandra E. Echeverria and Olveen Carrasquillo, "The Roles of Citizenship Status, Acculturation, and Health Insurance in Breast and Cervical Cancer Screening Among Immigrant Women," *Medical Care* 44, no. 8 (Aug. 2006): 788–92; and Greta A. Kilmer et al., "Hepatitis B Vaccination and Screening Among Foreign-Born Women of Reproductive Age in the United States, 2013–2015," *Clinical Infectious Diseases* (Epub ahead of print, June 1, 2018).

20. Adriana M. Reyes and Patricia Y. Miranda, "Trends in Cancer Screening by Citizenship and Health Insurance, 2000–2010," *Journal of Immigrant and Minority Health* 17, no. 3 (June 2015): 644–51.

21. Frost, *U.S. Women's Use,* 2009; and Tapales, Douglas-Hall, and Whitehead, "Sexual and Reproductive Health," 2018.

22. Frost, *U.S. Women's Use,* 2009.

23. Rachel K. Jones and Jenna Jerman, "Population Group Abortion Rates and Lifetime Incidence of Abortion: United States, 2008–2014," *American Journal of Public Health* 107, no. 12 (Dec. 2017): 1904–9.

24. Kate Coleman-Minahan and Goleen Samari, *How Removal of Immigrant Fathers Harms the Sexual Health and Wellbeing of Their Daughters* (Scholars Strategy Network, Feb. 2018); and Wendy Cervantes, Rebecca Ullrich, and Hannah Matthews, *Our Children's Fear: Immigration Policy's Effects on Young Children* (Center for Law and Social Policy, Mar. 2018).

25. Hasstedt, "Why We Cannot Afford," 2017.

26. Rachel Benson Gold, "'I Am Who I Serve' — Community Health Workers in Family Planning Programs," *Guttmacher Policy Review* 13, no. 3 (Aug. 2010).

27. Hasstedt, "How Dismantling the ACA's," 2017; and Adam Sonfield, "No One Benefits If Women Lose Coverage for Maternity Care," *Guttmacher Policy Review* 20 (June 2017).

28. Arijit Nandi, Sana Loue, and Sandro Galea, "Expanding the Universe of Universal Coverage: The Population Health Argument for Increasing Coverage for Immigrants," *Journal of Immigrant and Minority Health* 11, no. 6 (Dec. 2009): 433–36; Adam Sonfield, "Why Protecting Medicaid Means Protecting Sexual and Reproductive Health," *Guttmacher Policy Review* 20 (Mar. 2017); and Larissa Antonisse et al., *The Effects of Medicaid Expansion Under the ACA: Updated Findings from a Literature Review* (Henry J. Kaiser Family Foundation, Mar. 2018).

29. National Immigration Law Center, "Table: Medical Assistance Programs for Immigrants in Various States" (NILC, Jan. 2018); and Shannon McConville et al., *Health Coverage and Care for Undocumented Immigrants* (Public Policy Institute of California, Nov. 2015).

30. Artiga and Ubri, *Living in an Immigrant Family.*

31. Ann M. Starrs et al., "Accelerate Progress — Sexual and Reproductive Health and Rights for All: Report of the Guttmacher–*Lancet* Commission," *The Lancet Commissions* 391, no. 1040 (June 2018): 2642–92.

32. Hartling et al., *EPC Methods,* 2016.

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