United States of America

NGO assessment of the follow-up action of the US Government for ICCPR Recommendation Para. 15

CCPR/C/USA/CO/4
March 26, 2014 (adoption of the Concluding Observations)
March 26, 2015 (Deadline for the State follow-up report)

Current Status: April 1, 2015

The Center for Reproductive Rights is a global legal human rights organization that advances reproductive freedom as a fundamental human right that all governments are legally obligated to protect, respect, and fulfill.
[Contact: Katrina Anderson, kanderson@reprorights.org, reproductiverights.org]

This Advocacy Report Card will assess the U.S. Government's actions in response to the ICCPR Committee's Recommendation in para. 15 on Immigrants' Access to Health Care Coverage

As of 01 / May / 2015

Paragraph 15 (Immigrants): *"The Committee expresses concern about the exclusion of millions of undocumented immigrants and their children from coverage under the Affordable Care Act and the limited coverage of undocumented immigrants and immigrants residing lawfully in the United States for less than five years by Medic[aid] and [the] Children['s] Health Insurance [Program], all resulting in difficulties for immigrants in accessing adequate health care (arts. 7, 9, 13, 17, 24 and 26)."*

NGO Assessment of the Action of the State party on the Recommendations made by the Committee

Recommendation by the Committee	*"The Committee recommends that the State party… identify ways to facilitate access to adequate health care, including reproductive health-care services, by undocumented immigrants and immigrants and their families who have been residing lawfully in the United States for less than five years."* (para. 15)
Actions taken by the State party	The U.S. government has failed to remove existing discriminatory policies that restrict lawfully residing and undocumented immigrants' eligibility for federal public health coverage. Nor has the U.S. government identified ways to facilitate lawfully residing and undocumented immigrants' access to government health insurance through affordable public insurance programs, namely Medicaid and the Children's Health Insurance Program (CHIP). Since the Concluding Observations were issued in March 2014, the Obama administration has in fact ignored persistent calls for change from civil society to ensure equitable access to health care for immigrants under existing federal law and through any new executive actions that expand legal status. In November 2014, President Obama issued an executive action expanding eligibility for the Deferred Action for Childhood Arrivals (DACA) program (first introduced in an August 2012 executive action) and introducing the Deferred Action for Parental Accountability (DAPA) program.

	The newly-created DAPA program will provide an estimated 3.7 million immigrants temporary relief from deportation. Together, approximately 5.2 million immigrant children and parents will receive protection from deportation under the DAPA and DACA programs. However, implementing regulations for the DACA program issued by the Department of Health and Human Services in 2012 include harmful provisions that bar DACA recipients' eligibility for affordable healthcare coverage under Medicaid and CHIP as well as their participation in the health insurance marketplaces established under the Affordable Care Act (ACA).[1] Federal policy generally makes "lawfully present" immigrants, including those with deferred status, eligible for affordable health coverage under these programs, but these regulations amend the definition of "lawfully present" so that it does not apply to DACA grantees.[2] The administration has indicated that similar regulations will likely be developed for the DAPA program. These restrictions carve out special exceptions on health coverage for those granted deferred action under DACA. As such, they will further exacerbate disparities based on race, ethnicity, socioeconomic status, and other factors that the U.S. has acknowledged already exist at "unacceptably high levels." (U.S. Government report to Committee on the Convention to Eliminate Racial Discrimination, para. 133). This policy also runs counter to the government's claim in 2014 to the Human Rights Council that it is taking measures to eliminate health disparities and to ensure that "all people have access to health care and social service programs." (U.S. Government report to the Human Rights Council, para. 33). Federal restrictions on immigrants' eligibility for affordable health coverage are often reinforced at the state level. Texas, for example, has the third highest immigrant population and the highest population of uninsured people in the country. Instead of taking steps to address the coverage needs of its uninsured population, the state has further limited access to care generally for immigrants and access to reproductive health care specifically. Texas is one of only seven states that has refused to extend Medicaid coverage to *any* immigrants lawfully present in the U.S., no matter how long they have resided in the state (effectively disregarding the federal waiting period). These restrictions disproportionately impact immigrant women, who are less likely to have employer-based insurance and yet rely on the health care system more than men due to their reproductive needs. Meanwhile, some of the same states that limit immigrants' eligibility to health care are also attacking reproductive health services. In 2011, Texas dismantled its family planning program, causing dozens of reproductive health clinics to close in rural areas that were already federally designated as medically underserved. In 2013, the state took some steps to address the reproductive health crisis it had created, but state funds are still not reaching women in rural areas who are most in need. A 2014 state report showed that 26% fewer women received services in 2013 than in 2011 due to these policy changes, with women in border regions and other rural areas of the state even more impacted. Immigrant women who relied on these family planning clinics for contraception and cancer screenings remain without any source of affordable reproductive health care.
Current situation / Update of the Issue	The Department of Health and Human Services (HHS) has yet to issue implementing regulations for the DAPA program and, despite calls from civil society for an update on the procedural status, HHS has failed to note whether it will issue an interim final rule without a notice and comment period as it did for the DACA program. Moreover, DAPA's implementing regulations may be further delayed due to the challenge

[1] Immigration Policy, *A Guide to the Immigration Accountability Executive Action* (Mar. 13, 2015), http://www.immigrationpolicy.org/sites/default/files/docs/a_guide_to_the_immigration_accountability_executive_action_final.pdf

[2] 45 C.F.R. 152.2(8).

	brought by 26 states to President Obama's executive action on the expansion of the DACA and the creation of the DAPA program. On February 16, 2015, a federal judge in a Brownsville, Texas temporarily enjoined the executive actions issued by the President in November 2014. The case is now pending before a federal court of appeals. Congress also has the power to correct this problem but has failed to act. The Health Equity and Access under the Law (HEAL) for Immigrant Women and Families Act, reintroduced on April 22, 2015, would eliminate the five-year waiting period on Medicaid/CHIP eligibility for lawfully present immigrants. Moreover, the HEAL Immigrant Women and Families Act would make all immigrants who are granted deferred action, including those under DACA and DAPA who meet income qualifications, eligible for Medicaid/CHIP without a five-year delay. It would also allow them to apply for the cost sharing and tax credits available to help purchase private insurance through the ACA's marketplaces. Unfortunately, despite some strong champions, the bill has not garnered the full support it needs to move forward in the legislation process.
Impact of the Action of the State party (if any)	Policies barring qualified immigrants from eligibility for affordable health coverage discriminate against non-citizens and are unnecessarily punitive. Despite the fact that immigrants contribute federal taxes and may meet income eligibility requirements for federal health insurance programs, they cannot qualify for public insurance coverage based solely on their immigration status. Lack of insurance is the primary driver of health disparities in the U.S. Without access to affordable preventive care, immigrants often delay necessary health care or go without it altogether. Because of these barriers to preventive health care, foreign-born women experience worse reproductive health outcomes than native-born women. For example, while cervical cancer is nationally on the decline, the incidence and death rates for cervical cancer are increasing among immigrant women, who are less likely to have access to preventive care such as Pap tests. Since the Human Rights Committee's Concluding Observations in March 2014, the U.S. has not only failed to take the necessary measures to reduce these health disparities but has perpetuated policies that will only widen them.
Other Comments	In 2014, the CERD Committee echoed the Human Rights Committee's concern about U.S. policies restricting access to health insurance on the basis of immigration status, noting how such restrictions increase racial and gender disparities in health. The Committee urged the U.S. to "take concrete measures to ensure that all individuals, and in particular…undocumented immigrants, and immigrants and their families who have been residing lawfully in the United States for less than five years, have effective access to affordable and adequate healthcare services," in order to "eliminate racial disparities in the field of sexual and reproductive health."

Overall NGO Grades for the follow-up Action of the State party[3]: **A:** Action largely satisfactory; **B1**: Substantive action taken, but further action desirable; **B2**: Initial steps taken, but substantial action required; **C1**: Some actions taken, but recommendations are not really implemented; **C2**: No action taken; **E**: measures taken are contrary to the recommendations	**E (based on failure to remove restrictive policies on coverage and new plans to expand such restrictions in federal regulations to apply to additional categories of immigrants)**

[3] The NGO Grades are made in accordance with the assessment grades of the HR Committee (see the page 1) so that both grades can be directly compared