

Section 5. Health Care and Social Assistance

from

All in for a Thriving Connecticut

Opportunities to Support Upward Mobility for the State's Immigrant Families

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5 Health Care and Social Assistance

Access to means-tested social assistance programs and affordable public insurance is often instrumental for low-income families struggling to meet basic needs for nutrition, health care, and stable housing. Research has demonstrated that such programs reduce poverty, improve physical and mental health outcomes, and promote educational and developmental advancements for children—all of which contribute to economic mobility and social integration.⁹³ However, immigration-status-related restrictions on access to public benefits programs—and misunderstandings of those rules—have long blocked many immigrant families from accessing needed supports. Under federal law, lawful permanent residents (LPRs, also known as green-card holders) who have held that status for five years are generally eligible for federally funded public benefits such as Medicaid and the Supplemental Nutrition Assistance Program (food stamps) if they meet income and other program requirements, while unauthorized immigrants and temporary visa holders are ineligible for most federally funded public benefits.

While states cannot change the federal eligibility rules for means-tested programs, state governments can create state-funded programs to improve immigrant families' access to needed supports. Connecticut has opted to create state-funded replacement programs to provide cash assistance, food assistance, and public health insurance to some noncitizens who are excluded from federal benefits.⁹⁴ This section will focus predominantly on HUSKY, Connecticut's Medicaid and Children's Health Insurance Program (CHIP).

Under current law, federally funded HUSKY is available to low-income U.S. citizens, refugees and asylees, and LPRs with at least five years in that status, along with smaller numbers of immigrants who are survivors of trafficking, Cuban/Haitian entrants, or in other humanitarian statuses. (Beginning in October 2026, refugees and asylees, survivors of trafficking, and some other smaller groups will lose access to federally funded health insurance coverage, due to provisions in the *One Big Beautiful Bill Act of 2025*.⁹⁵) In Connecticut, federally funded insurance is also available to LPRs who are children or pregnant and who have fewer than five years of U.S. residence, and CHIP funding can be used for prenatal care for pregnant individuals, regardless of immigration status.⁹⁶ State-funded HUSKY was extended in 2023 to children up to age 12 who are part of income-qualifying families and whose immigration status made them ineligible for federally funded insurance. In July 2024, HUSKY was extended to children age 15 and under.⁹⁷

93 Arloc Sherman and Tazra Mitchell, *Economic Security Programs Help Low-Income Children Succeed Over Long Term, Many Studies Find* (Washington, DC: Center on Budget and Policy Priorities, 2017).

94 Connecticut provides cash assistance, similar to the Temporary Assistance for Needy Families (TANF) program, to lawful permanent residents (LPRs) in their first five years in that status; such immigrants are ineligible for federally funded TANF. And Connecticut makes certain federally ineligible immigrant groups who have lived in the state for more than six months eligible to receive food assistance benefits at 75 percent of the standard federal amount under the Supplemental Nutrition Assistance Program (SNAP), including certain Violence Against Women Act (VAWA) self-petitioners, T-visa applicants with bona fide determinations, and Special Immigrant Juvenile (SIJ) status and U-visa grantees who have adjusted to LPR status but not yet met the standard five-year residency requirement for SNAP. See Valerie Lacarte, Lillie Hinkle, and Briana L. Broberg, *SNAP Access and Participation in U.S.-Born and Immigrant Households: A Data Profile* (Washington, DC: Migration Policy Institute, 2023); Urban Institute, "Welfare Rules Database, Policy Tables," Table I.B.6, accessed February 24, 2025.

95 National Immigration Law Center (NILC), "New Law Limits Health Care & Food Aid for Immigrants," updated July 31, 2025.

96 Kaiser Family Foundation (KFF), "Medicaid/CHIP Coverage of Lawfully-Residing Immigrant Children and Pregnant Women, as of January 2025," accessed July 15, 2025; KFF, "Medicaid and CHIP Income Eligibility Limits for Pregnant Women as a Percent of the Federal Poverty Level, as of January 2025," accessed July 15, 2025.

97 Maricarmen Cajahuaringa, "CT Kids Ages 15 and Younger Now Qualify for Husky Health Care, Regardless of Immigration Status," Connecticut Public Radio, July 1, 2024.

Access to public health insurance ensures that low-income individuals can receive necessary medical care, preventing minor health issues from becoming severe and creating high costs for both households and medical providers. Connecticut hospitals faced \$239 million in uncompensated costs for care due to uninsured individuals (only a portion of whom are immigrants) in 2021, the latest year for which such information is available.⁹⁸

As of April 2025, nearly 920,000 individuals—immigrants and U.S. born—were enrolled in Medicaid or CHIP in Connecticut.⁹⁹ In 2019–23, 29 percent of low-income immigrants in Connecticut were uninsured, compared to 5 percent of low-income U.S.-born state residents.¹⁰⁰ Connecticut’s expansions of state-funded public health insurance to children covered about 15,000 children as of Spring 2025.¹⁰¹

Looking ahead, major changes to Medicaid eligibility rules and financing, and changes to tax credits available to those purchasing private insurance, are projected to reduce the share of both immigrants and U.S.-born individuals with health insurance coverage, greatly increasing costs to states.¹⁰² Many of these provisions will not take effect until 2026 or 2027.¹⁰³ When they do, they are likely to complicate state decision-making on how to help low-income residents of all backgrounds in seeking health insurance coverage and access to quality care.

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A. Key Trends and Challenges

Federally qualified health centers are central to providing health care to low-income and/or federally ineligible immigrant families.

Federally qualified health centers (FQHCs) are crucial to supporting low-income immigrant families in Connecticut, providing accessible health-care services at little to no cost, even to those lacking health insurance. These centers serve as vital resources for low-income and underserved populations, including immigrants, who often face barriers to accessing traditional health-care services. Seventeen FQHC providers (operating hundreds of sites) and additional look-a-likes in the state offer a wide range of services, including primary, dental, mental health, and preventive care, regardless of a patient’s immigration status or ability

98 Medicaid and CHIP Payment and Access Commission (MACPAC), *Annual Analysis of Medicaid Disproportionate Share Hospital Allotments to States* (Washington, DC: MACPAC, 2024).

99 Centers for Medicare and Medicaid Services, “March 2025 Medicaid & CHIP Enrollment Data Highlights,” accessed July 29, 2025.

100 Migration Policy Institute (MPI) analysis of data from the U.S. Census Bureau’s American Community Survey (ACS), pooled for 2019–23.

101 State of Connecticut, Data and Policy Analytics Unit, “CT Data—DSS Types of Assistance (TOA) Participation by Month CY 2012–2025,” accessed April 28, 2025.

102 Jennifer Scholtes, Robert King, and Benjamin Guggenheim, “GOP Megabill’s Final Score: \$3.4T in Red Ink and 10 Million Kicked off Health Insurance, CBO Says,” Politico, July 21, 2025; Rhiannon Euhus, Elizabeth Williams, Alice Burns, and Robin Rudowitz, “Allocating CBO’s Estimates of Federal Medicaid Spending Reductions Across the States: Enacted Reconciliation Package,” KFF, July 23, 2025.

103 KFF, “Implementation Dates for 2025 Budget Reconciliation Law,” accessed August 5, 2025.

to pay.¹⁰⁴ As rural hospitals in the state restrict their labor and delivery services, and major hospital groups expand increasingly privatized practices in metropolitan areas, FQHCs' presence in places where immigrant families live has become increasingly important for connecting them to health care.¹⁰⁵

Another example of public health-care services in Connecticut is school-based health centers (SBHCs), which play a significant role in supporting immigrant children by providing a direct health-care touchpoint in their schools. The more than 300 SBHCs in the state (many of which are also FQHCs) make it easier for children to access essential services such as vaccinations, physical exams, mental health support, and chronic illness management, without arranging transportation to a clinic or missing school.¹⁰⁶ SBHCs often employ bilingual/cultural staff (English–Spanish, most commonly), professionals who understand the unique needs of immigrant communities, work to build trust with families wary of engaging with institutions due to status insecurity, and encourage them to use non-emergency health-care services.¹⁰⁷

Changes may be ahead for some immigrants' access to FQHCs. In July 2025, the U.S. Department of Health and Human Services (HHS) issued a notice that the federal funding stream for FQHCs, the HHS Health Center Program, would now be considered a "federal public benefit," for which immigrant eligibility restrictions apply.¹⁰⁸ Under this policy change, only "qualified" immigrants—including naturalized citizens, green-card holders, refugees and asylees, and members of certain smaller humanitarian groups—would be eligible for FQHC services. Temporary work or student visa holders, unauthorized immigrants, Temporary Protected Status (TPS) holders, and those with Deferred Action for Childhood Arrivals (DACA) would be made newly ineligible for FQHC services. However, as of the time of writing, much remains to be seen about how this policy change will be implemented. By law, nonprofit organizations cannot be required to verify immigration status, and most FQHCs are nonprofit organizations. Litigation over this policy change seems likely.

Many immigrant households struggle to find affordable and timely specialized health care.

Beyond basic care, immigrant households in Connecticut face even more significant barriers to accessing specialized medical care. One of the primary challenges is a lack of insurance coverage, whether because an immigrant does not qualify for HUSKY or because their job does not provide employer-based insurance. Without coverage, the high cost of specialized care becomes a significant obstacle, leading many to forgo services such as preventive screenings or treatment for chronic conditions. And even for immigrants who are insured, language barriers can make it difficult to communicate effectively with health-care providers, understand medical instructions, and advocate for one's health needs in a specialist system that is unfamiliar and largely based on referrals.

104 A federally qualified health center (FQHC) look-a-like is a community health center that meets all the requirements to be considered an FQHC, but does not receive federal grant funding under the Health Center Program. See U.S. Department of Health and Human Services, Health Resources and Services Administration, "HRSA Data Warehouse—Find A Health Center," accessed July 29, 2025.

105 Author interview with health-care advocates, June 20, 2024; Katy Golvala, "CT Approves Closure of Labor and Delivery at Johnson Memorial Hospital," CT Mirror, November 14, 2024.

106 Cris Villalonga-Vivoni, "Many Connecticut School-Based Health Centers Are Seeing a Rise in Student Visits," CT Insider, October 20, 2024.

107 Author interview with health-care provider, June 24, 2024.

108 U.S. Department of Health and Human Services, "HHS Bans Illegal Aliens from Accessing its Taxpayer-Funded Programs" (press release, July 10, 2025).

Of the myriad medical specialization needs of immigrant patients, key stakeholders interviewed for this report highlighted two areas of particular concern: mental health support and maternal health services.¹⁰⁹ On top of the systemic barriers outlined above, the stigma and differences in cultural understanding surrounding mental and maternal health issues form an additional barrier. Further compounded by the limited number of bilingual providers, long wait times, financial constraints, and lack of providers accepting public health-care coverage, immigrant families often struggle to receive specialized care until an emergency surfaces. Periods of heightened fear about immigration enforcement can also deter immigrants without a secure legal status from seeking non-emergency medical care.

Transportation, housing, and language access are some of the most significant barriers to health care experienced by newcomers.

Transportation is a critical barrier to health care for many newcomers in Connecticut, as many immigrants rely on public transportation or lack access to reliable transportation.¹¹⁰ In an environment where health-care options, particularly for HUSKY patients, are decreasing due to clinic and hospital closures, some families may have to travel further to reach a facility that can accommodate them. Evidence suggests that individuals facing transportation barriers are more likely to delay or miss essential health-care visits, which can lead to worsening conditions and increased emergency response scenarios.¹¹¹ Similarly, housing instability complicates health-care access for immigrants—especially new arrivals—as lacking a permanent address can disrupt stable access to care from a regular provider, and environmental factors such as substandard housing can exacerbate existing medical conditions.¹¹² When housing is unstable, it also becomes more complicated to prioritize health care among other pressing needs, and studies have documented links between housing instability and higher morbidity.¹¹³

Language barriers, as mentioned above, present another significant obstacle, preventing many immigrants from effectively communicating with health-care providers or understanding their medical options. While health-care providers are required, under federal and state law, to facilitate access to their services for limited English proficient individuals,¹¹⁴ effective interpretation services are not always available, particularly for low-incidence languages. Often, family members are asked to provide interpretation, but they may lack the specialized medical vocabulary. Limited access to translation services and/or reimbursement for translation services can lead to misunderstandings, inadequate care, and a reluctance to seek medical assistance, leaving many immigrant families without the support they need to navigate the health-care system.¹¹⁵

109 Author interview with health-care advocates, June 20, 2024; author interviews with health-care providers, June 24, 2024 and June 29, 2025.

110 Author interview with health-care provider, June 24, 2024.

111 Samina T. Syed, Ben S. Gerber, and Lisa K. Sharp, “Traveling Towards Disease: Transportation Barriers to Health Care Access,” *Journal of Community Health* 38, no. 5 (2013): 976–993.

112 Author interview with health-care provider, June 24, 2024.

113 Lauren A. Taylor, “Housing and Health: An Overview of the Literature” (policy brief, Health Affairs, Washington, DC, 2018).

114 Mara Youdelman, “What Is Required under Title VI and Section 1557 to Ensure Language Access for Individuals with Limited English Proficiency?” National Health Law Program, May 9, 2024; State of Connecticut, “Interpreter Services and Linguistic Access in Acute Care Hospitals,” *Connecticut General Statutes*, Title 19a, Chapter 368v, Section 19a-490i (2024).

115 Mamata Pandey et al., “Impacts of English Language Proficiency on Healthcare Access, Use, and Outcomes among Immigrants: A Qualitative Study,” *BMC Health Services Research* 21 (2021): 741.

B. Recommendations

1. Adapt the public outreach and service delivery strategies of health-care programs to reflect the state's shifting demographic trends and immigration landscape

To effectively address the shifting demographics of Connecticut and its immigrant population, health-care programs must be nimble in adapting to translation and interpretation needs and to changing federal and state policies affecting health-care access for immigrants of varying immigration statuses. Because video and phone interpretation can inhibit trust and clear communication between providers and patients, effective communication with those not fluent in English can best be achieved by increasing the availability of in-person interpretation services, revising funding/insurance reimbursement structures for translation services, and expanding the use of multilingual health-care materials in low-incidence languages that are increasing in prevalence, such as Haitian Creole. In addition, health-care providers, postsecondary institutions, elected officials, and other stakeholders should continue to advance efforts to ensure that needs for bilingual and bicultural health-care workers are routinely tracked and incorporated into system planning and quality improvement initiatives.

To effectively address the shifting demographics of Connecticut and its immigrant population, health-care programs must be nimble in adapting to translation and interpretation needs.

Organizations that offer HUSKY enrollment assistance and health-care providers could also develop policies responsive to the increased variety of immigration statuses held by Connecticut residents, given larger numbers with statuses that fall in between legal and unauthorized immigrant categories, such as humanitarian parole, pending asylum claims, and TPS. This could include providing detailed information about who is and is not eligible for HUSKY and how that eligibility might change next year under recent federal legislation. It could also include carefully explaining to immigrants the circumstances under which information provided to the state in order to enroll in HUSKY might be shared with immigration enforcement agencies, in light of federal efforts to share federally funded Medicaid enrollees' personal information with U.S. Immigration and Customs Enforcement (ICE).¹¹⁶ To ensure that all those eligible for HUSKY are being enrolled, the state Medicaid office could conduct trainings to ensure staff are aware of the Medicaid eligibility of humanitarian populations admitted into the United States in recent years. And they could collaborate closely with immigrant-serving organizations, schools, and grassroots advocacy groups to increase the availability of information and enrollment touchpoints to new, underserved populations. Finally, funders and policymakers can support efforts to connect immigrants to health care through funding safety-net health-care services that are available to people who are uninsured, regardless of immigration status, including to meet pressing needs for maternal and mental health care.

¹¹⁶ Kimberly Kindy and Amanda Seitz, "Trump Administration Hands over Medicaid Recipients' Personal Data, Including Addresses," Associated Press, July 17, 2025. Data provided by enrollees in state-funded HUSKY is not shared with the federal government. As of the time of writing, a coalition of 20 state attorneys general, including Connecticut Attorney General William Tong, had filed suit to block this data sharing with U.S. Immigration and Customs Enforcement (ICE). See Connecticut Office of the Attorney General, "Attorney General Tong Sues Trump Administration for Illegally Sharing Personal Health Data with ICE" (press release, July 1, 2025).

2. Leverage local partnerships to advance more holistic service provision

To sustain more holistic, wraparound services that address the multifaceted needs of immigrant communities in Connecticut, health-care providers and the state Medicaid office could consider leveraging strategic partnerships between human services providers, community-based organizations, educational institutions, and other community institutions that are well-connected to vulnerable groups. Collaborating with trusted community organizations already serving immigrant populations can enhance service delivery and health-care outcomes by integrating social support systems such as legal assistance, housing, and employment resources. Policymakers and funders could consider resourcing partnerships between, for example, the Fairfield County-based nonprofit Family Centers and a community nutrition access organization, or between Yale School of Medicine and social services organizations.¹¹⁷ Such partnerships can create a seamless network of support that addresses medical needs and the social determinants of health that significantly affect immigrant communities.

3. Consider expanding HUSKY or private insurance eligibility to include all immigrants, regardless of status, and increase Medicaid reimbursement rates

While expansions to HUSKY have covered thousands of previously excluded noncitizen children, many noncitizen residents of the state are still left out.¹¹⁸ Extending HUSKY coverage to all individuals regardless of age and immigrant status would help improve all low-income families' access to needed medical care. Research suggests that this level of expansion would increase access to preventive care, decrease reliance on emergency care services, and improve overall economic and public health.¹¹⁹ Recognizing these benefits, several states (including California, Minnesota, and Oregon) and Washington, DC, have enacted policies to extend state-funded health insurance coverage to all residents, regardless of status.¹²⁰ (Some have recently scaled back their coverage or paused enrollment due to funding shortfalls.¹²¹) Alternatively, Connecticut could continue on its trajectory of iterative expansions of HUSKY coverage for noncitizens by age, prioritizing teens and young adults or older adults. To enable noncitizens to feel comfortable enrolling in state-funded public health insurance in the current environment, service providers may need to emphasize that while the federal government has sought data from states on Medicaid enrollees, this request does not extend to data on recipients of public health insurance solely funded by states. Enhanced state data privacy laws could also help uptake amid any future expansions.

The expansion of who is covered by public health insurance would require substantial investments by the state, as well as significant planning around expanding the network of providers accepting HUSKY. One way to grow this network would be to increase Medicaid reimbursement rates. A 2024 report by Connecticut's Department of Social Services found that the state's reimbursement rates are markedly lower than those of peer states,

117 Author interview with health-care provider, July 24, 2024.

118 Author interview with health-care advocates, June 20, 2024.

119 Gabriel Zieff, Zachary Y. Kerr, Justin B. Moore, and Lee Stoner, "Universal Healthcare in the United States of America: A Healthy Debate," *Medicina* 56, no. 11 (2020): 580.

120 Valerie Lacarte, Julia Gelatt, and Ashley Podplesky, *Immigrants' Eligibility for U.S. Public Benefits: A Primer* (Washington, DC: MPI, 2024).

121 Akash Pillai, Drishti Pillai, and Samantha Artiga, "Recent State Actions Impacting Immigrants' Access to State-Funded Health Coverage and Other Public Programs," KFF, July 16, 2025.

suggesting the state is overdue for a revision to its rates.¹²² Higher reimbursement rates can incentivize more private providers to accept Medicaid patients, U.S. born and immigrant alike, enhancing access to quality care and reducing wait times for those relying exclusively on public services.¹²³ In 2025, Connecticut’s legislature allocated nearly \$80 million to increase Medicaid reimbursements to community health centers over the next three years, but the funding amount is contingent on federal reimbursement rates holding steady, and even the full increase falls short of what Connecticut’s health centers, clinics, and hospitals have been seeking.¹²⁴

Connecticut could also consider options to boost immigrant residents’ ability to purchase private insurance. Three states—Colorado, Maryland, and Washington—have found ways to open private health insurance markets to some immigrants without legal status, and Colorado provides subsidies for those with incomes below 300 percent of the federal poverty level. Washington had also offered subsidies, but ended their availability in 2025.¹²⁵ Under federal law, immigrants who are not lawfully residing in the United States are excluded from *Affordable Care Act* (ACA) health insurance exchanges and from associated subsidies for low-income individuals. However, Colorado has established a separate insurance exchange platform for excluded individuals and requires insurance companies that sell plans through the state’s ACA marketplace to also offer plans on this separate exchange. Washington State and Maryland have obtained a federal waiver that allows excluded immigrants to enroll in the states’ marketplaces.¹²⁶ Connecticut could likewise explore models to open more pathways to private insurance for immigrants of all immigration statuses, with or without also offering subsidies.

4. Consider other public benefits and tax credit expansions to support immigrant household well-being, following examples from other states

Connecticut has been a national leader in expanding the rights and benefits available to immigrants of all legal statuses. But other states have gone further in providing economic, health, and other supports to immigrants who are excluded from federal programs. For example, ten states now offer their state Earned Income Tax Credit (EITC) to residents who pay their income taxes using an Individual Taxpayer Identification Number—a number available to taxpayers who cannot access a Social Security Number, including many unauthorized immigrants. State EITCs can help to provide needed economic support to low-income immigrant families, helping them to cover basic living expenses.¹²⁷ Colorado, meanwhile, has established a state-funded alternative to federal unemployment insurance for workers who lose their jobs but do not qualify for unemployment insurance due to their immigration status.¹²⁸ Considering such examples, Connecticut could explore whether there are further ways to support the health and economic well-being of its immigrant families.

122 Connecticut Department of Social Services, Division of Health Services, *Phase 1 Report: Studies of Medicaid Rates of Reimbursement* (Hartford: Connecticut Department of Social Services, 2024); Katy Golvala, “CT Medicaid Underpays Many Health Care Providers,” CT Mirror, February 19, 2024.

123 Author interview with health-care advocate, July 31, 2024.

124 Governor Ned Lamont, “Governor Lamont Announces Agreement to Support Community Health Centers with Boost to Medicaid Reimbursement Rates” (press release, July 16, 2025); Katy Golvala, “Health Centers to Withdraw CT Medicaid Rate Petition after Budget Earmark” CT Mirror, June 10, 2025.

125 Akash Pillai, Drishti Pillai, and Samantha Artiga, *State Health Coverage for Immigrants and Implications for Health Coverage and Care* (San Francisco: KFF, 2024). Maryland’s coverage will start in November 2025.

126 Gabrielle Lessard, “On the Path Toward Health for All: Opportunities for States to Expand Access to Private Coverage through State Innovation Waivers” (policy brief, NILC, December 2023).

127 NILC, “Map of States that Offer Earned Income Tax Credits (EITCs) to Taxpayer Identification Numbers (ITINs) Filers,” updated July 1, 2023.

128 Tanya Broder and Isobel Mohyeddin, *States Continue to Invest in the Health and Well-Being of Immigrants: Highlights from 2023* (Los Angeles, CA: NILC, 2024).