

ASPE ISSUE BRIEF

OFFICE OF THE ASSISTANT SECRETARY FOR PLANNING AND EVALUATION
OFFICE OF HUMAN SERVICES POLICY - U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

THE AFFORDABLE CARE ACT: COVERAGE IMPLICATIONS AND ISSUES FOR IMMIGRANT FAMILIES

Project Purpose

The Immigrant Access to Health and Human Services project maps and describes the legal and policy contexts that govern and affect immigrant access to health and human services. Through a synthesis of existing information, supplemented by in-depth visits to purposively selected sites, the study aims to identify and describe federal, state, and local program eligibility provisions related to immigrants, major barriers (such as language and family structure) to immigrants' access to health and human services for which they are legally eligible, and innovative or promising practices that can help states manage their programs.

Introduction

The 2010 Affordable Care Act (ACA) includes a number of provisions that will expand access to subsidized health insurance coverage to the non-elderly population, including immigrants.

Major provisions of the ACA include:

- The expansion of Medicaid up to 133 percent of the federal poverty level¹;
- New state-based health insurance exchanges combined with insurance market reforms;
- Premium subsidies for individuals with incomes below 400 percent of the Federal Poverty Limit (FPL) and cost-sharing subsidies for individuals with incomes below 250 percent FPL; and
- An individual requirement to obtain health insurance coverage.

According to projections by the Congressional Budget Office, the ACA will reduce the uninsured rate by 11 percentage points, reducing the share without insurance coverage from 19 to 8 percent by 2017 when most key provisions will be fully phased in,

ABOUT THIS ISSUE BRIEF

This Issue Brief is one of several under the "Immigrant Access to Health and Human Services" project; for more information see <http://aspe.hhs.gov/hsp/11/ImmigrantAccess/index.shtml>.

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with the largest gains occurring among those with lower-incomes (CBO, 2010). The ACA will expand the coverage options for some, but not all immigrant groups. Indeed, undocumented immigrants, who are prohibited from enrolling in Medicaid and purchasing coverage through the new health insurance exchanges, are projected to constitute 25 percent of the uninsured after the major provisions of the ACA are fully implemented (Buettgens et al., 2010). In addition, options available to lawfully residing immigrants under the ACA also depend on the number of years they've lived in the United States. This brief highlights the demographic, socioeconomic, and geographic characteristics and uninsured rates for key immigrant subgroups and describes how the ACA could affect coverage and access to care for these subgroups and their families. The ACA has particular relevance for the United States' foreign-born population since they are over 2.5 times more likely than their native-born peers to be uninsured (33.7 percent compared to 12.8 percent, respectively) and because they constitute a large and growing share of the US population (Pew Hispanic Center, 2011).

The following section describes the data source for the estimates included in this brief, the American Community Survey (ACS). Subsequent sections contain estimates of the foreign-born population, describe relevant ACA coverage provisions with respect to immigrant subgroups in more detail, and discuss their potential impacts.

Data and Methods

The estimates presented in this brief derive from the ACS, which is an annual survey fielded continuously throughout the year by the United States Census Bureau. This analysis uses an augmented version of the ACS, the Integrated Public Use Microdata Series (IPUMS) prepared by the University of Minnesota Population Center (Ruggles et al., 2010).

The ACS includes information on individual and family demographic characteristics. Based on the respondent's answers to the survey's panel of health insurance questions and information collected about other members of the household, we classify an individual's health insurance status as follows:

- 1) *Medicaid/CHIP*—Covered through either Medicaid or CHIP, regardless of whether or not individual has other source(s) of coverage;
- 2) *Employer*—Covered under a current or former employer or union (of this person or another family member), TRICARE or another military health care program;
- 3) *Other Public*—Covered through Medicare or Veterans Affairs (VA);
- 4) *Directly Purchased*—Insurance purchased directly from an insurance company;
- 5) *Uninsured*—Lacks any of the above types of coverage. This includes individuals with Indian Health Service (IHS) coverage, which is not officially counted as health insurance coverage because of limitations in the scope of available services and the geographic reach of IHS facilities.

These classifications are made hierarchically, such that individuals with more than one type of coverage are assigned to the single coverage category that is highest on the hierarchy. For example, respondents who report having both Medicaid and employer sponsored coverage are categorized in the Medicaid/CHIP insurance category.

There is concern that the ACS may understate Medicaid and CHIP coverage and overstate non-group coverage (Lynch and Boudreaux, 2010). To improve ACS coverage data on Medicaid/CHIP and non-group coverage, we apply a set of logical edit rules to correct likely misreported coverage that is inconsistent with other information collected in the survey. The edit rules are based on eligibility rules and enrollment procedures for Medicaid and CHIP and other information that suggest that enrollment in Medicaid or CHIP may not have been accurately reported (Kenney et al., 2011).

We define individuals in our sample as being in one of four categories: US native born (born in the US or US territories), naturalized citizens, non-citizens with five years or less US residency, and non-citizens with more than five-years US residency. We use these classifications because of unique provisions in the ACA that apply to individuals in each category.

We analyze variation in the composition of the native born, naturalized citizens, non-citizens with five years or less US residency, and non-citizens with more than five-years US residency for the following characteristics:

- 1) Age—Reported age of individual.
- 2) Income—Income estimates are based on a Health Insurance Unit (HIU), which represents members of a nuclear family who would be covered under a private health insurance policy. Income is defined as percent of the federal poverty level (using thresholds set by the Census Bureau) based on gross income.²
- 3) Family Work Status—Reports collective work status of immediate family unit living in the same household (parents and spouses).
- 4) Race/Ethnicity—Reported race of individual.³
- 5) Citizenship Status within the HIU—Summarizes citizenship status of different members of the HIU.
- 6) Language—Reported language spoken at home by the individual.
- 7) Linguistic Isolation—Defined as households in which no person age 14+ speaks only English at home and no person age 14+ who speaks a language other than English at home speaks English "Very well". All members of such a household are considered linguistically isolated, even though children under 14 who speak only English may live there.
- 8) State—Reported state of residency of household.

Variation within states can be assessed on the American Community Survey using Public Use Microdata Areas (PUMAs). PUMAs number more than 2,000 nationally and are often defined in terms of counties, though PUMAs can cover a combination of whole counties or a part of a large county.⁴

Snapshot of Foreign-Born Population in 2009

Our estimates indicate that in 2009, 30.3 million non-elderly adults and 3.1 million children were born outside of the United States.⁵ Of these, collectively, 39.7 percent were naturalized citizens.⁶ Access to public health insurance is limited for certain categories of the foreign born by law. The Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA) of 1996 generally restricted Medicaid access to “qualified immigrants”⁷ residing in the United States prior to the passage of the bill and to immigrants residing in the US under qualified status for five years or more.^{8,9} As a proxy for these two groups, we provide separate estimates for non-citizens who have more than five year’s residency in the US and those who have less than five year’s residency.

The socio-demographic composition of the foreign born differs from the native-born citizen population along a number of different dimensions (Exhibit 1). Roughly half (49.9 percent) of non-citizens who have been in the country five years or less have incomes below 138 percent of the Federal Poverty Level (FPL), compared to 41.9 percent for non-citizens who have been in the country for more than five years and 27.4 and 20.5 percent for US born citizens and naturalized citizens, respectively. Relative to US born citizens, the foreign born are much more likely to be Hispanic or Asian and to speak a non-English language in their home. Fully 44.9 percent of non-citizens who have been in the country five years or less and 34.0 percent of non-citizens who have been in the country more than five years live in linguistically isolated households. Many households contain both citizens and non-citizens: for example, just over half (51.8 percent) of non-citizens who have been in the country for more than five years live with citizens.

Exhibit 1: Characteristics of the Non-Elderly, by Immigration Status and Years of Residency

	US Native Born		Naturalized Citizens		Non-Citizens With 5-Years or Less US Residency		Non-Citizens With More than 5-Years US Residency	
	Count (thousands)	Percent	Count (thousands)	Percent	Count (thousands)	Percent	Count (thousands)	Percent
Total-Nonelderly	230,145	-----	13,271	-----	6,067	-----	14,078	-----
Age								
0-18	75,838	33.0%	651	4.9% *	1,284	21.2% *	1,148	8.2% *
19-24	22,205	9.6%	636	4.8% *	1,127	18.6% *	1,079	7.7% *
25-34	32,351	14.1%	2,027	15.3% *	1,891	31.2% *	3,792	26.9% *
35-54	69,722	30.3%	7,049	53.1% *	1,496	24.7% *	6,742	47.9% *
55-64	30,029	13.0%	2,908	21.9% *	268	4.4% *	1,316	9.3% *
Income								
<138 FPL	62,183	27.4%	2,703	20.5% *	2,967	49.9% *	5,862	41.9% *
138-400 FPL	85,928	37.9%	5,271	39.9% *	2,017	34.0% *	5,762	41.2% *
401+ FPL	78,835	34.7%	5,231	39.6% *	957	16.1% *	2,376	17.0% *
Family Work Status								
Two Full-time	44,966	19.5%	3,147	23.7% *	560	9.2% *	2,057	14.6% *
One Full-time	112,610	48.9%	6,836	51.5% *	3,140	51.8% *	7,681	54.6% *
Part-time Only	36,475	15.8%	1,487	11.2% *	1,046	17.2% *	2,125	15.1% *
Not Working	32,004	13.9%	1,760	13.3% *	1,147	18.9% *	2,136	15.2% *
Child Not Living with Parents	4,091	1.8%	41	0.3% *	173	2.9% *	79	0.6% *
Race								
Hispanic	28,563	12.4%	4,332	32.6% *	2,762	45.5% *	9,345	66.4% *
White	159,832	69.4%	3,039	22.9% *	1,051	17.3% *	1,796	12.8% *
Black or African American	30,139	13.1%	1,244	9.4% *	509	8.4% *	835	5.9% *
Asian/Pacific Islander	4,540	2.0%	4,441	33.5% *	1,663	27.4% *	1,952	13.9% *
American Indian	1,741	0.8%	10	0.1% *	5	0.1% *	6	0.0% *
Other/Multiple	5,330	2.3%	205	1.5% *	77	1.3% *	143	1.0% *
Citizenship Status within HIU								
All HIU Memebers are Citizens	218,866	95.1%	11,615	87.5% *	-----	-----	-----	-----
Mixed HIU Citizenship	11,280	4.9%	1,655	12.5% *	1,628	26.8% *	7,289	51.8% *
No Citizens in HIU	-----	-----	-----	-----	4,439	73.2% *	6,789	48.2% *
Language								
English Spoken in HH	186,860	81.2%	2,640	19.9% *	596	9.8% *	1,530	10.9% *
Spanish Spoken in HH	16,483	7.2%	4,123	31.1% *	2,621	43.2% *	9,163	65.1% *
Chinese Spoken in HH	548	0.2%	945	7.1% *	324	5.3% *	400	2.8% *
Filipino, Tagalog Spoken in HH	356	0.2%	707	5.3% *	368	6.1% *	351	2.5% *
Hindi & Related Spoken in HH	205	0.1%	334	2.5% *	155	2.6% *	233	1.7% *
Korean Spoken in HH	275	0.1%	619	4.7% *	102	1.7% *	126	0.9% *
Vietnamese Spoken in HH	192	0.1%	715	5.4% *	212	3.5% *	246	1.8% *
Other Spoken in HH	25,226	11.0%	3,187	24.0% *	1,689	27.8% *	2,028	14.4% *
Linguistic Isolation								
Linguistic Isolation	4,820	2.1%	2,020	15.2% *	2,726	44.9% *	4,791	34.0% *
No Linguistic Isolation	225,325	97.9%	11,251	84.8% *	3,340	55.1% *	9,286	66.0% *
State								
California	23,762	10.3%	3,614	27.2% *	1,176	19.4% *	3,807	27.0% *
Texas	18,241	7.9%	1,054	7.9% *	666	11.0% *	1,891	13.4% *
New York	13,238	5.8%	1,675	12.6% *	589	9.7% *	1,249	8.9% *
Florida	12,251	5.3%	1,208	9.1% *	519	8.5% *	1,097	7.8% *
Illinois	9,683	4.2%	622	4.7% *	237	3.9% *	661	4.7% *
Rest of US	152,971	66.5%	5,098	38.4% *	2,879	47.5% *	5,373	38.2% *

Source: Urban Institute analysis of 2009 IPUMS ACS.

Notes: Estimates show number and share of nonelderly, noninstitutionalized, civilian population in a specific immigration status bracket by characteristic. Estimates reflect an adjustment for the misreporting of coverage on the ACS. Adjusted coverage estimates were developed under a grant from the Robert Wood Johnson Foundation. * Denotes estimate is statistically different from US Native Born estimate at the 0.05 level.

Non-citizens are also heavily clustered in several states, and in particular geographic regions. Over half (53 percent) of non-citizens with five years or less US residency and 62 percent of non-citizens with more than five years US residency live in either California, Texas, New York, Florida, or Illinois. In contrast, these states contain only 34 percent of the native born population and 37 percent of the entire US nonelderly population (data not shown). Those same five states also contain about 55 percent of unauthorized immigrants and nearly a quarter (23 percent) lives in California alone. Fully 77 percent of the unauthorized population can be accounted for in just 12 states (Passel and Cohn, 2011).

The non-citizen share varies substantially from state to state (Exhibit 2). In the lowest third of states, non-citizens constitute between 0.6 and 3.0 percent of the non-elderly population while in contrast, non-citizens constitute more than 7.0 percent of the non-elderly population for states in the top third. CA has the largest share (15.4 percent) of non-citizens among its nonelderly population. The non-citizen share also varies within states (data not shown). For example, in California, the share of non-citizens in the ten areas with the highest concentration of non-citizens is 30 percent or higher, whereas the share of non-citizens in the ten areas with the lowest concentration of non-citizens is below 5 percent (Exhibit 3).

Nationally, over half (50.6 percent) of non-citizen nonelderly adults are uninsured, which compares to 17.6 percent for citizen adults (Exhibit 4). Non-citizens constitute 23.4 percent of uninsured nonelderly adults despite making up just 9.6 percent of all nonelderly adults (data not shown). Non-citizen adults are also less reliant on employer sponsored insurance (data not shown) despite non-citizen adults being almost equally likely as native born or naturalized citizen adults to live in a household where at least one person is employed (data not shown). Only 35.4 percent non-citizen adults are covered by ESI whereas 65.0 percent of adults who are citizens are covered through an employer (data not shown). Non-citizen adults reside in a household with at least one worker at a rate of 66.9 percent, whereas citizen adults are 67.3 percent likely to do so (data not shown).

Non-citizen children have lower uninsured rates than non-citizen adults but still have much higher uninsured rates compared to children who are citizens (Exhibit 4). Overall, 35.3 percent of non-citizen children who have been in the country five years or less and 42.0 percent who have been in the country more than five years are uninsured while 7.4 percent of US born children and 9.8 percent of naturalized citizens are uninsured.¹⁰ Only 26.5 percent of non-citizen children are covered by ESI compared to 53.1 percent of citizen children who are covered through an employer sponsored plan, despite a much narrower gap between noncitizen and citizen children in terms of likelihood to be living in a family with at least one full-time worker. Almost two-thirds of noncitizen children live in a family with at least one full-time worker, and 72.2 percent of citizen children live in a family with at least one full-time worker. Among citizen children, the citizenship status of other HIU members is also an important correlate to being uninsured. Among citizen children, both native born and naturalized, 13.5 percent (1.3 million) are uninsured of the 9.5 million in mixed citizenship HIUs while just 6.6 percent (4.4 million) are uninsured in HIUs comprised of all citizens (data not shown).

Exhibit 2: Proportion of Nonelderly who are Non-Citizens in the United States

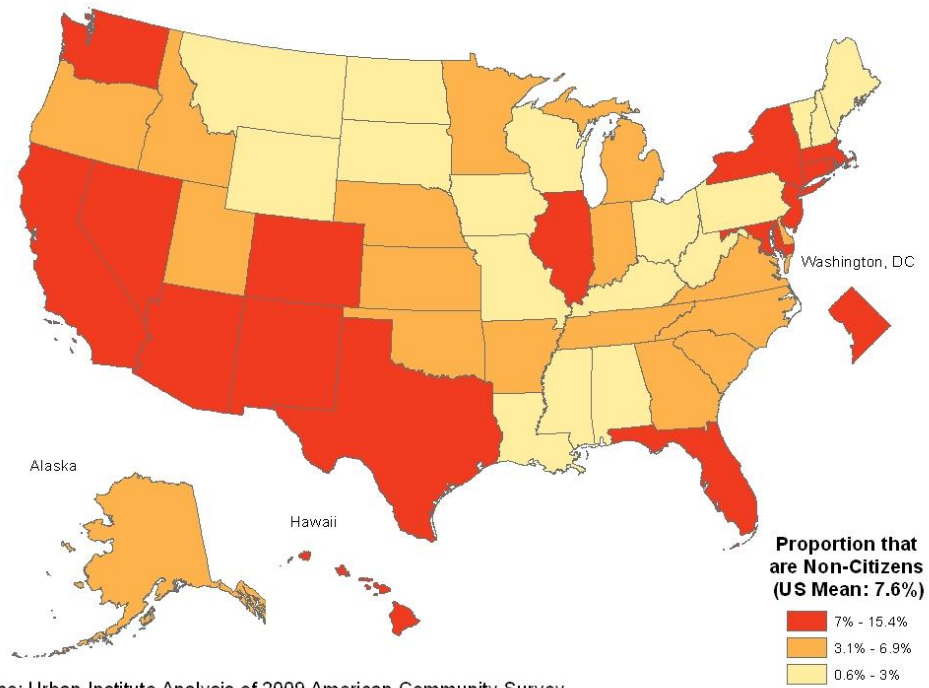


Exhibit 3: Proportion of Nonelderly who are Non-Citizens in California

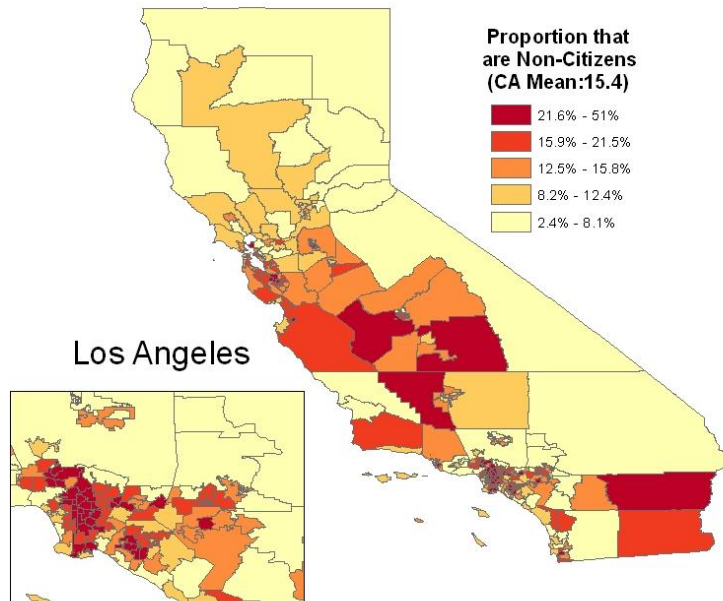
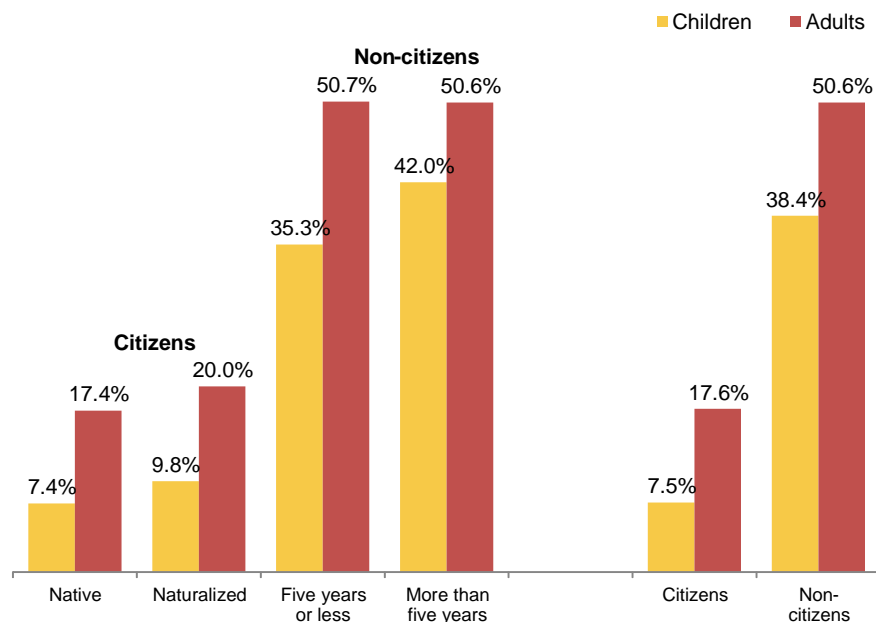


Exhibit 4: Uninsurance Estimates for Adults and Children by Citizenship Status



Source: Urban Institute analysis of 2009 American Community Survey.

Notes: Uninsurance estimates for naturalized citizens, non-citizens with 5-years or less US residency, and non-citizens with more than 5-years US residency are statistically different at the 0.05-level from estimates for native citizens, for both children and adults. Estimates for non-citizens are also statistically different from citizens. Estimates reflect an adjustment for the misreporting of coverage on the ACS. Adjusted coverage estimates were developed under a grant from the Robert Wood Johnson Foundation.

The Affordable Care Act

The ACA includes a number of provisions that expand access to affordable health insurance coverage. The principal mechanisms through which it does this include an expansion of Medicaid, the creation of state-based health insurance exchanges, the provision of income-based subsidies for exchange coverage, and a requirement that individuals acquire health insurance. The law also includes provisions aimed at achieving high take up in Medicaid and Children’s Health Insurance Program (Medicaid/ CHIP). In addition, the ACA addresses issues that are of more particular relevance for immigrants, related to reducing health care disparities and reallocating federal funding for a number of federal programs in response to anticipated changes in the number and composition of both those who are insured and uninsured after the ACA is fully implemented.

Current Law

Under current law, publicly subsidized health insurance coverage is available to children to a much greater extent than it is to non-elderly adults¹¹. Moreover, there is substantial variation across states with respect to eligibility policies under Medicaid and CHIP. In 2009, the median eligibility threshold for children under Medicaid and CHIP was 241 percent of the FPL; the median eligibility threshold for parents (defined as those living with a child under the age of 19) was at 64 percent of FPL for working parents and 37 percent for nonworking parents; and more than half of states did not provide any coverage for non-disabled childless adults. In addition to state variation across income groups, 21 states and the District of Columbia have opted to use federal dollars made available by the Children’s Health Insurance Program Reauthorization Act of 2009 (CHIPRA) to cover otherwise eligible immigrant children who have been legally residing in the United States for less than five-years.¹² Seventeen states and the District of Columbia took advantage of a similar provision

under CHIPRA that permits coverage of pregnant immigrant women who had been in the country for five years or less under Medicaid and CHIP (Fortuny and Chaudry, 2011; Heberlein et al., 2011)¹³.

Under the ACA, the eligibility expansions that have occurred for children under CHIPRA will also be kept in place through the Maintenance of Effort (MOE) provision. It requires states to maintain the eligibility standards, methodologies, and procedures in place for Medicaid until January 1, 2014 for adult coverage, and in place in Medicaid and CHIP until September 30, 2019 for children's coverage. This means that lawfully residing immigrant children will retain current coverage options in Medicaid and CHIP in states that currently provide them through September 30, 2019. The eligibility provisions for pregnant immigrant women with five years or less of residency in the United States in the 18 states (including DC) that elected this coverage option under CHIPRA, will not be subject to the special MOE provision for children, although children's coverage provided in either a State Plan Amendment or through a Medicaid or CHIP waivers will be subject to it. Undocumented immigrants that receive coverage through state-funded programs will not be protected by the MOE (Guyer and Heberlein, 2011).

Coverage Expansions and Subsidies

The ACA sets a uniform minimum eligibility threshold under Medicaid at 133 percent of the FPL for both children and adults. Relative to current policy, the ACA will substantially expand access to insurance Medicaid coverage for poor and near-poor adults who are citizens (both native born and naturalized) and for most lawfully residing noncitizens that have been in the country more than five years.¹⁴ Lawfully residing immigrant adults who have been in the country five years or less will not be eligible for Medicaid coverage, and neither would undocumented immigrants. As now, lawfully residing immigrant children who have been in the country less than five years will be eligible for Medicaid coverage at state-option.

The ACA includes new health insurance subsidies for those with incomes up to 400 percent of the FPL. It establishes an Essential Benefits package that all plans in the exchanges, or offered in the individual and small group markets outside the exchanges, must provide at minimum.¹⁵ As with Medicaid, undocumented adults and children will not be eligible for subsidies in the exchanges; in addition, they will be barred from purchasing unsubsidized coverage through the exchanges. However, qualified non-citizens will be eligible for exchange subsidies, regardless of how long they have been in the U.S. Their access to the exchanges and available subsidies will be the same as for citizens, and will represent a substantial increase in the affordability of insurance for low and moderate income immigrants. Lawfully present immigrants with five years or less of US residency, without access to employer sponsored insurance, will be able to receive both premium tax credits and cost sharing tax credits towards approved plans that meet the essential benefits package outlined in the ACA. This includes such immigrants whose incomes are below 133 percent FPL and so, but for immigration status, would receive Medicaid.

These subsidies decrease with income. The premium tax credit is structured such that the premiums that would be paid do not exceed a specified percentage of income for a designated plan, which varies between 2 percent of income for those at 133 percent of poverty to 9.5 percent for those at 400 percent poverty. The 2 percent cap applies to all persons below 133 percent poverty, with no further reductions as income decreases. The cost-sharing subsidies apply to individuals below 250 percent of the FPL, with higher subsidies provided to those with lower incomes and cost-sharing subsidies flattening out at 100 percent FPL.

The individual mandate in the ACA requires, with certain exceptions, that citizens and lawfully residing immigrants have minimum essential coverage or pay a penalty (the mandate does not apply to undocumented immigrants). The mandate excludes those with incomes below the threshold necessary to file taxes or to those whose contribution to their health insurance, after subsidies, would exceed 8 percent of their income (Kaiser Family Foundation, 2011). For example, married couples under age 65 were required to file federal

income taxes in 2010 if their 2009 gross income exceeded \$18,700, or 85 percent of FPL for a family of 4.¹⁶ These exceptions to the individual mandate are likely to apply to some immigrants with incomes below 138 percent of the FPL, since some will have incomes below the tax-filing threshold. Some immigrant families who have income well below 138 percent FPL could still be subject to the mandate however since federal income tax filing thresholds do not increase with family size, unlike FPL.

While the cost of attaining health care for the poorest legal immigrants with five years or less residency will decrease due to premium and cost sharing subsidies, they may still find it unaffordable (Dorn, March 2011). Although many lawfully present immigrants are subject to the mandate, as indicated above, many at the lowest income bracket will be excluded from the mandate, as they will be below the threshold necessary to file taxes.

Other Coverage Options and Issues

Other options to cover the poorest immigrants with five years or less US residency exist in the ACA. For those under 30 who are exempt from the mandate because health insurance would cost more than 8 percent of their income, plans may offer catastrophic coverage that doesn't meet the criteria necessary to qualify as a bronze, silver, gold, or platinum plan. They would offer limited benefits but at low premiums.

Some young, uninsured immigrants will gain coverage through the ACA's expansion of dependent coverage up to age 26 in plans that offer dependent coverage, including employer plans and those purchased in the non-group market (Kenney, Pelletier and Blumberg, 2010) though it is not clear how many will have access to coverage through their parents.

Another option available to states is to create a Basic Health Program (BHP). Under this option, states would create a federally financed option for low income adults (between 133 and 200 percent FPL) and qualified lawfully present immigrants ineligible for Medicaid.¹⁷ Depending on its design, the BHP option could offer coverage with much lower premium and out-of-pocket costs to these groups relative to what would be available under the exchange. While BHP plans must be at least as generous as coverage offered in the exchange, a state could go beyond that minimum threshold and provide Medicaid "look-alike" coverage to low-income adults and poor immigrants ineligible for Medicaid (Dorn, 2011).

Funding Changes for Safety-Net Providers

The ACA also provided, starting in 2011 and extending for five-years, 11 billion dollars in additional funding for community health centers (CHCs), which have traditionally been an important source of care to low-income populations, particularly those who are uninsured. In addition, the ACA required plans offered in the exchange to contract with CHCs, using the same cost-based reimbursement principles that apply in Medicaid. The newly enacted federal budget removed \$600 million in appropriations for community health centers for the remainder of 2011 (NACHC, 2011). It is not clear how much CHC capacity will expand given the projected funding levels. By 2019, the estimated number of people they would serve given anticipated funding levels specified in the ACA is projected to grow substantially (NCSL, 2011a). It is likely that CHCs will be an even more important source of care for immigrants who remain uninsured following the full implementation of the ACA. In the coming years, it is expected that immigrants, particularly undocumented immigrants and those with five years or less residency in the country, will constitute an even larger share of the uninsured, given that they will not benefit from the Medicaid expansion that will cover other formerly uninsured immigrant groups and citizens.

States currently use federal disproportionate share hospital (DSH) payments to adjust upward Medicaid payments for hospitals that serve low-income populations, who are generally heavily reliant on Medicaid or are uninsured. DSH functions to adjust, in large part, for uncompensated care, although states have considerable latitude as to how they allocate their DSH funds. The Medicaid expansion under ACA will change the distribution of uncompensated care since poor citizens and immigrants with more than five years residency will receive insurance through Medicaid. Starting in 2014 DSH allotments will be gradually reduced through 2020 resulting in a loss of approximately 18.1 billion dollars for states (ACA also reduces Medicare DSH payments). The methodology for determining which states will receive Medicaid DSH funds is not yet in place, but the guidelines for establishing a methodology are outlined in the ACA. They impose the greatest reductions on states with the fewest uninsured and states that do not target their DSH dollars towards hospitals serving Medicaid patients and the uninsured. This is essentially how funds are supposed to be distributed currently, but there is wide variation across states in how DSH funds are allotted per uninsured individual. Given the uncertainty in how DSH funds will be apportioned, it is unclear how providers serving populations of the uninsured will be affected by these reductions in funds. Pending changes in the allocation of DSH funds may affect providers' willingness and ability to serve these immigrants who remain uninsured (Burke and Martin, 2010).

Targeted Provisions for Immigrants in ACA

In addition to creating a standardized, essential health benefit package through the exchange, the ACA provides numerous provisions aimed at reducing disparities in access to care (NCSL "Disparities in Health", 2011). The ACA mandates that qualified insurance plans in the exchange provide informational materials in a culturally and linguistically appropriate manner for the intended audience. HHS issued guidance which calls for plans that have significant non-English speaking populations among their enrollees to translate materials into alternative languages (Youdelman, 2011a). Grant money was also designated to establish federal offices that focus on minority health,¹⁸ create a more diversified health care work force that would be better able to serve minority communities, and collect detailed data on minority health access and outcomes (Foster, 2010).

CHIPRA included an option for states to receive an enhanced federal match-rate for translation services provided to CHIP enrollees and children enrolled in Medicaid.¹⁹ Previously, states were only able to be reimbursed at the standard administrative matching rate of 50% for translation services. States had been able to reimburse providers who bundled these services with the care they delivered at the standard FMAP rate, but there was no obligation for Medicaid and CHIP to cover these services delivered through providers. Currently only thirteen states have added this option to their State Plan.²⁰

Potential Coverage Impacts under the ACA

Naturalized Citizens and Lawfully Present Immigrants with More Than Five Years Residency

The ACA will greatly expand access to free or subsidized health insurance coverage for the millions of naturalized citizens and for documented non-citizens who have been in the country for more than five years. Together, the Medicaid expansion to 138 percent of the FPL and the new subsidies that will be available for exchange coverage should lead to substantial national reductions in uninsurance among naturalized citizens and lawfully residing immigrant adults that have been in the country for more than five years with incomes below 400 percent of the Federal Poverty Level. Gains will be most pronounced for non-elderly adults with incomes below 400 percent of the FPL who live in states that currently cover very few non-disabled adults and parents in Medicaid. Of the five states that have the largest number of immigrants, the largest improvements in coverage are likely to occur in Florida and Texas, where today Medicaid covers very few non-disabled adults (Buettgens et al., 2011).

It is expected that the ACA will also increase insurance coverage among immigrant children, though smaller effects are anticipated for children than for adults because more children are currently insured through higher Medicaid/CHIP income eligibility thresholds and through state use of the CHIPRA option to cover immigrant children with less than five years in the U.S. (Buettgens et al, 2010; Kenney, Pelletier, and Blumberg, 2010). Participation in Medicaid/CHIP is expected to rise among children who are already eligible for coverage under the ACA because of the expansion of Medicaid to more parents and because of the mandate on coverage (GAO, 2011). At the same time however, prior research indicates that non-citizen children and citizen children with non-citizen parents participate in Medicaid and CHIP at lower rates compared to citizen children that have citizen parents (Kenney et al., 2011). Therefore, additional efforts may be needed to address barriers to enrollment and retention among these children and their parents. For example, translation services, application assisters, and electronic enrollment options may facilitate enrollment of immigrant families. Also, targeted outreach efforts may be needed to reach parents whose primary language is not English and to address fears that enrollment in Medicaid/CHIP and receipt of exchange subsidies for children could be affected by or affect a parent's immigration status or ability to become a citizen, or that it could have adverse effects on immigrant sponsors. In addition, special attention may be needed to address the needs of uninsured children who qualify for Medicaid or exchange subsidies but whose parents do not qualify because of their immigration status (McMorrow et al., 2011).

Lawfully Residing Immigrants with Five Years or Less US Residency

Access to subsidized coverage will also expand under the ACA for non-elderly lawfully residing immigrants with incomes below 400 percent of the Federal Poverty Level who have been in the country five years or less. As indicated above, adults in this immigrant category with incomes below 400 percent of the FPL who do not have access to affordable employer-sponsored insurance will be eligible for subsidized coverage in the health insurance exchange; those with incomes below 138 percent of the FPL will not be eligible for Medicaid coverage (except pregnant women under the state option) but can qualify for exchange subsidies if they pay two percent of income. This cost sharing requirement may constitute a barrier to enrollment for some immigrants in this category, particularly for those with incomes below 100 percent FPL. Also, subsidies for out-of-pocket cost-sharing will provide much less generous coverage than that offered through Medicaid, so even if poor immigrant families enroll, many may delay necessary care because of cost. Although qualified immigrants are subject to the mandate, some at the lowest income bracket will be excluded. For lawfully residing immigrant children who have been in the country five years or less, their eligibility for Medicaid and CHIP will continue to depend on the state in which they live—those in the 22 states that have opted to cover these children will maintain eligibility for Medicaid and CHIP given the maintenance of effort requirement under the ACA, while other states may choose to take advantage of this coverage option under CHIPRA. As described above, increasing participation among eligible immigrant children will likely depend on addressing a range of different enrollment barriers. Lawfully residing immigrant children who have been in the country five years or less with incomes below 400 percent of the FPL who live in one of the 29 states that are not required by the MOE to continue covering them under Medicaid or CHIP, or who do not live in a state that opts to cover them with state funds, will qualify for subsidized coverage through exchange plans under the ACA, which may in turn reduce their uninsured rates.

Unauthorized Immigrants

Unauthorized immigrants will not be eligible for Medicaid or CHIP coverage or for exchange subsidies under the ACA and will not be permitted to purchase unsubsidized coverage through the exchange. They are not subject to the mandate and are excluded from temporary high-risk pools but will remain eligible for emergency care under Medicaid, if they would otherwise meet the eligibility criteria for Medicaid (NILC,

2010). The coverage of emergency services should help hospitals that provide services to this population and will likely reduce medical billings to families with undocumented members. While some states may continue covering undocumented children with state funds, they are not bound to do so under the ACA. It is not clear whether and how access to health care will change for the undocumented under the ACA. First, while they will not gain access to subsidized coverage, they may benefit from the fact that other family members, who are documented, will be able to qualify for Medicaid or subsidized coverage which should, among other things, reduce financial burdens on the entire family. Second, their access to care will likely depend on the ability and willingness of safety net providers to serve them, to the extent services go beyond screening and stabilizing treatment for emergency medical conditions, which are legally required from hospitals that accept Medicare reimbursement.²¹ On the one hand, as indicated above, the ACA provides additional funding for CHCs, an important source of care for the uninsured, although current budget cuts have limited the funds made available to CHCs in the health reform bill (NCSL, 2011b). Additionally, the reduction in the total uninsured population in the US following health reform may enable providers to cross-subsidize care for the remaining uninsured, a quarter of which will be undocumented immigrants. On the other hand, the reduction in DSH spending could cause some providers to cut back on uncompensated care they provide to the uninsured.

Summary

- Naturalized citizens and lawfully residing immigrants who have been in the US for more than five years will have the same opportunities to obtain more affordable health insurance coverage as native-born citizens under the ACA: those with incomes below 138 percent of the FPL will be eligible for Medicaid and those with incomes between 138 and 400 percent of the FPL that lack access to “affordable” employer-sponsored coverage will qualify for subsidized coverage under the new exchanges. Thus, the ACA is expected to lead to substantial reductions in uninsured rates among these immigrant groups. Projected impacts will be strongest for immigrants who live in states that do not currently cover many non-elderly adults in their Medicaid programs and in those that achieve high take up among the Medicaid and exchange eligible population.
- Lawfully residing immigrants who have been in the US for five years or less will have access to coverage through the health insurance exchanges and to premium and cost-sharing subsidies, but generally will not be eligible for Medicaid/CHIP²² (except for children who can be covered at state option). Given that many in this group have incomes below 138 percent of the FPL but will not be eligible for Medicaid coverage, some may continue to face affordability barriers even after the ACA is fully implemented.
- Unauthorized immigrants will not be allowed to purchase insurance from the exchanges, receive subsidies for exchange coverage, or enroll in full-scope Medicaid and thus will likely remain uninsured at very high rates. Their access to primary and other forms of outpatient care will depend on the ability and willingness of local safety net providers, such as community health centers, to serve them, which will likely vary from area to area.
- Achieving high rates of take-up for Medicaid and exchange subsidies among immigrant families will likely require addressing language barriers to enrollment and addressing issues facing mixed immigrant status families, in which many citizen children live. Among other things, the ACA requires health plans in the exchange to provide information in a culturally and linguistically appropriate manner, which may be critical to achieving higher take-up since many immigrants live in linguistically isolated households.

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¹ The eligibility threshold is effectively 138 percent, since 5 percent of income is disregarded when determining eligibility.

² Gross income differs slightly from the measure of income that will be used for eligibility determinations under the ACA, modified adjusted gross income (MAGI), which disregards some sources of income.

³ We define anyone who reported being "Hispanic" or "Latino" as Hispanic, and define single race-only for non-Hispanics.

⁴ Public Use Microdata Areas (PUMAs) are Census-constructed mutually exclusive geographic entities that do not cross state lines and that generally follow the boundaries of county groups, single counties, or census-defined "places."

⁵ The foreign-born excludes individuals born abroad to American parents and those born in outlying U.S. territories (Guam, U.S. Virgin Islands, Northern Marianas) and the Commonwealth of Puerto Rico. These individuals are considered native born in these analyses.

⁶ According to a recent report that focuses on the entire population, including the elderly, 28 percent of the foreign born were undocumented, 35 percent were non-citizens who are lawfully residing immigrants and 37 percent were naturalized citizens (Pew Hispanic Center, 2011).

⁷ Qualified immigrants are defined as immigrants who are considered for eligibility for means-tested benefits under PRWORA: Legal Permanent Residents (LPRs), refugees and asylees, persons paroled into the US for at least one year, persons granted withholding of deportation/removal, battered spouses and children (with a pending or approved spouse visa or a self-petition for relief under the Violence Against Women Act), Cuban and Haitian entrants, and victims of severe human trafficking. Non-qualified immigrants include persons with temporary protected status, asylum applicants, other lawfully present immigrants (students or workers) and unauthorized immigrants (Fortuny and Chaudry, 2011). They also include some immigrants who qualified for Medicaid before PRWORA as permanent residents under color of law (PRUCOL) as well as immigrants who qualify for tax credits under the ACA as lawfully present in the United States.

⁸ Among post-enactment qualified immigrants with less than 5 years residency, only refugees, asylees, and other immigrants exempt on humanitarian grounds, veteran and active duty military members and their spouses and children are considered eligible to receive Medicaid or CHIP (Fortuny and Chaudry, 2011).

⁹ See subsequent section for a description of provisions available under the Children's Health Insurance Program Reauthorization Act that allowed states to cover qualified immigrant children and pregnant women with less than five years residency in the United States.

¹⁰ While no definitive information is available to explain why non-citizen children with longer residency in the US are more likely to be uninsured, a number of explanations are possible. Non-citizen children with longer residency in the US are likely to be older and are more likely to be undocumented relative to non-citizen children who have been in the US for a shorter period of time

(<http://www.kff.org/medicaid/loader.cfm?url=/commonspot/security/getfile.cfm&PageID=14713>), which would contribute to higher uninsured rates. In addition, this comparison applies only to non-citizen children; if instead, foreign-born children who become naturalized were included, the picture would likely be different.

¹¹ States are required to cover qualified children up to 133 percent of the poverty line under six years old and up to 100 percent of the poverty line for six to 18 year olds. Some states cover 6 to 18 year olds between 100 and 133 percent FPL in Medicaid; others do so in CHIP.

¹² Currently California, Connecticut, Delaware, District of Columbia, Hawaii, Iowa, Maine, Maryland, Massachusetts, Minnesota, Montana, Nebraska, New Jersey, New Mexico, New York, North Carolina, Oregon, Rhode Island, Texas, Virginia, Washington, and Wisconsin have a State Plan Amendment (SPA) to cover immigrant children legally residing in the US for five years or less. Colorado also has passed legislation to cover this population with state funds but, as of January 2011, has not provided necessary state funding. Illinois and Pennsylvania have submitted SPA's to CMS to cover this population, but currently cover them with state funds. Prior to the CHIPRA option to use federal dollars to cover this group, 17 states had been using state dollars to cover them. In addition, four (Washington, New York, Illinois, New Jersey, and District of Columbia) currently cover undocumented children with state funds and Alaska covers qualified immigrants for certain medical conditions with state-only funding.

¹³ California, Colorado, Connecticut, Delaware, District of Columbia, Hawaii, Maine, Maryland, Massachusetts, Minnesota, Nebraska, New Jersey, New Mexico, New York, North Carolina, Texas, Washington, and Wisconsin currently have a State Plan Amendment to cover immigrant pregnant women legally residing in the US for five years or less. Details of the Essential Health Benefits requirements will be contained in regulations to be issued by HHS.

¹⁴ Alabama, Mississippi, North Dakota, Ohio, Texas, Virginia, and Wyoming restrict coverage among qualified immigrants, even after the five-year ban, to Legal Permanent Residents with 40 quarters of work, military members and veterans (and their spouses/children), refugees, asylees and other immigrants in protected statuses (Fortuny and Chaudry, 2011).

¹⁵ Essential Health Benefits must include, at minimum, the following services: ambulatory patient services, emergency services, hospitalization, maternity and newborn care, mental health benefits and substance use disorder services, prescription drugs, rehabilitative and habilitative services and devices, laboratory services, preventive and wellness services and chronic disease managements, and pediatric services including oral and vision care.

¹⁶ Because filing thresholds are based on fixed dollars amounts and filing status, without any adjustment based on family size, those thresholds cannot be stated as a percentage of FPL that applies to all families. For example, if a family of 3 files as a married couple, the same filing threshold mentioned in the text would apply, even though, for such a family, it would equal 102 percent of FPL. A single parent acting as head of household must file a tax return if he or she receives at least \$12,000 in gross income, which amounts to 82 percent FPL for a family of 2, 65 percent FPL for a family of 3, etc. (Internal Revenue Service, 2009).

¹⁷ If states elect the BPH option, the populations eligible for BPH would no longer be eligible to participate in the exchange. BPH federal funding would cover all the costs of covering lawfully residing immigrants not eligible for Medicaid (Dorn, 2011).

¹⁸ Offices were established in HHS, CDC, HRSA, SAMHSA, AHRQ, FDA, and CMS. (Foster, 2010)

¹⁹ The greater of either 75 percent or the state's FMAP plus 5 percent. (CMS Guidance, July 2010)

²⁰ Hawaii, Iowa, Idaho, Kansas, Maine, Minnesota, Montana, New Hampshire, Utah, Vermont, Washington, Washington DC, and Wyoming (Youdelman, 2011b).

²¹ 42 U.S.C. §1395dd (1986).

²² Exemptions include children covered by the MOE who reside in states that currently cover them with federal funds, and children and adults in specific groups excluded from the five-year ban (refugees, asylees, and other immigrants exempt on humanitarian grounds, and veteran and active duty military members and their spouses and children).