Supporting Health Equity and Affordable Health Coverage for Immigrant Populations: State-Funded Affordable Coverage Programs for Immigrants

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STATE Health & Value STRATEGIES | *Driving Innovation Across States*

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Introduction

The crisis in immigrant health coverage has been both highlighted and exacerbated by the recent pandemic. COVID-19 has taken a heavy toll on immigrants, who are disproportionately frontline/service workers, making them particularly vulnerable to the virus.[1] Indeed, approximately 70 percent of all immigrants in the United States (U.S.) workforce are employed as essential workers.[2] Research affirms that foreign-born individuals are at higher risk of COVID-19 mortality, with one recent study establishing Latino(a) immigrants of working age as more than 11 times as likely to die from COVID-19 than U.S.-born non-Latino(a) individuals.[3] High rates of uninsurance among the nation's immigrant population are compounding COVID-19's impact. While the Patient Protection and Affordable Care Act (ACA) led to significant gains in health coverage by insuring more than 20 million people, nearly 30 million individuals remained uninsured as of 2019.[4,5] Immigrants (including "lawfully present" and undocumented individuals) make up 23 percent of the uninsured nationally.[6] The uninsured immigrant population, which includes those who are ineligible for government sponsored coverage due to citizenship status, has few viable options for affordable health coverage, except for emergency care.

Access to affordable health coverage and healthcare for immigrant populations in the U.S. is critical to advancing health equity and reducing health disparities. In recent months, many states and localities have focused on covering the remaining uninsured and providing access to healthcare as COVID-19 continues to surge. To cover low-income residents who are ineligible for subsidized health insurance under the ACA or through Medicaid/the Children's Health Insurance Program (CHIP), states are pursuing legislative or administrative actions to extend affordable healthcare coverage to all residents, regardless of immigration status, using state-only funds ("state-funded affordable coverage programs"). While this approach has gained traction in recent months, many states and localities had already established these types of programs prior to the pandemic as an effective public health strategy to address longstanding social, economic, and health inequities.

This issue brief—the first in a series "Supporting Health Equity and Affordable Health Coverage for Immigrant Populations"—provides an overview of the national immigrant health coverage landscape and offers considerations for policymakers related to state-funded affordable coverage programs for low-income individuals who do not qualify for subsidized health insurance under the ACA or other public programs due to immigration status.

Potential Eligibility for Federally Funded Coverage Programs Based on Immigrations Status

An individual must be lawfully present (authorized to live in the U.S.) in order to be potentially eligible for federally funded health coverage programs. In general, lawfully present immigrants can purchase coverage through the Marketplace and access federal subsidies to offset the cost of that coverage. Only lawfully present immigrants with a "qualified" status can be eligible for Medicaid/CHIP, and some qualified immigrant populations must wait five years after obtaining lawful status before they can enroll in Medicaid/CHIP coverage, while others, such as refugees and victims of trafficking, are exempt from this "five-year bar." States also have the option under the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA) to expand Medicaid coverage to lawfully present children and pregnant individuals, regardless of whether they are qualified.[7] In contrast, individuals who are undocumented and those with Deferred Action for Childhood Arrivals (DACA) status ("Dreamers"), among others, are ineligible for health insurance under the ACA (and are prohibited from purchasing Marketplace coverage even without subsidies), with the exception of temporary, limited scope coverage for emergency services ("emergency Medicaid").[8] The uninsured immigrant population in the U.S. includes people who are eligible for health insurance under the ACA or other public programs but are not enrolled, as well as those

who are ineligible for government sponsored coverage due to citizenship status. Even when immigrants are eligible for coverage, in recent years they haved faced barriers to enrollment including the "chilling effect" from Public Charge[i] and other exclusionary immigration policies that have adversely impacted the take up of health coverage.

Table 1: Potential Eligibility for Federally Funded Coverage Programs Based on Immigration Status

Immigration Status	Marketplace Eligible[9]	Medicaid/CHIP Eligible[10]
Lawfully Present and Eligible for Federally Funded Coverage Programs		
Valid non-immigrant visa holders (e.g., student visas, worker visas)	✔	✘
Humanitarian statuses or circumstances (including Temporary Protected Status, Special Juvenile Status, asylum applicants, Convention Against Torture, victims of trafficking)	✔	✘
Legal status conferred by other laws (temporary resident status, Legal Immigration Family Equity Act, Family Unity individuals)	✔	✘
Qualified non-citizens • Lawful Permanent Residents [(LPR)/Green Card Holder)]* • Paroled into the U.S. for at least one year* • Battered non-citizens, spouses, children, or parents* • People fleeing persecution (e.g., asylees, refugees) • Granted withholding of deportation • Cuban/Haitian entrants • Certain Amerasian immigrants • Members of a federally recognized Indian tribe or American Indian born in Canada • Veterans or active duty military and their family members • Victims of trafficking and their family members • Citizens of the Marshall Islands, Micronesia, and Palau who are living in one of the U.S. states or territories ["Compact of Free Association (COFA) migrants"][ii] • Granted Iraqi or Afghan special immigrant status • Children receiving foster care or adoption assistance • Conditional entrant granted before 1980	✔	✔

[i] Public charge determinations apply when immigrants enter the country or apply for a green card, and individuals can be deemed inadmissible if they are found likely to become "primarily dependent on the government for subsistence." Under longstanding Public Charge guidance, which was updated during the Trump administration but reinstated this year, using Medicaid (other than long-term care), CHIP, and Marketplace are not considered in Public Charge determinations.

[ii] Section 208 of the Consolidated Appropriations Act, 2021 eliminated the five-year bar for COFA migrants, restoring access to Medicaid after a drafting error in the 1996 Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA) excluded this population from coverage.

Table 1: Potential Eligibility for Federally Funded Coverage Programs Based on Immigration Status		
Immigration Status	**Marketplace Eligible[9]**	**Medicaid/CHIP Eligible[10]**
Ineligible for Federally Funded Coverage Programs Due to Immigration Status		
Undocumented immigrants • Individuals who entered the country without authorization • Individuals who entered the country lawfully and stayed after their visa or status expired	✗	✗[iii]
DACA: Temporary status allowing individuals who came to the country as children to remain in the U.S.	✗	✗
Deferred Action for Parents of Americans and Lawful Permanent Residents (DAPA): Temporary status allowing parents of citizens or LPRs to remain in the country	✗	✗

**Subject to the five-year bar (i.e. requirement to reside in the U.S. for five years or more before becoming eligible for Medicaid/CHIP). Note that there is no five-year bar for accessing subsidized Marketplace coverage.*

State-Funded Affordable Coverage Programs for Immigrants: National Landscape

States are relying on two predominant models to offer access to affordable coverage for immigrant populations that are ineligible for federally funded health coverage: (1) establishing state Medicaid/CHIP equivalent or comparable programs; and (2) creating state premium or cost-sharing subsidies to enable individuals to purchase Marketplace coverage.

State coverage solutions for immigrants are being advanced primarily by leveraging state Medicaid/CHIP programs to provide access to coverage for children and adults. As of September 2021, six states (California, Illinois, Massachusetts, New York, Oregon, Washington) and the District of Columbia (D.C.) are implementing affordable Medicaid/CHIP equivalent or comparable coverage programs subsidized through state funds for low-income children and adults who do not qualify for subsidized health insurance under the ACA or through other public programs like Medicaid/CHIP, including because of their immigration status. The following table summarizes state-funded coverage programs that are currently in effect and build on states' Medicaid/CHIP programs to provide affordable healthcare for immigrant populations.

[iii] The federal government matches state costs for emergency Medicaid services.

Table 2: Implemented State-Funded Affordable Coverage Programs for Immigrants[iv]				
State	**Program**	**Eligibility**	**Benefits**	**Cost-Sharing**
Immigrant Children and Adolescents				
CA	Health4All Kids	Age 18 and younger with income < 266% of the federal poverty level (FPL)	Full scope Medicaid equivalent benefits	Copayments: None Premiums: For enrollees with incomes > 160% and < 266% of the FPL; premiums amount to $13 per month per child ($39 family max)
D.C.[v]	Immigrant Children's Program	Age 20 and younger with income ≤ 200% of the FPL	Full scope Medicaid equivalent benefits	Copayments: None Premiums: None
IL	All Kids	Age 18 and younger with income < 318% of the FPL	Full scope Medicaid equivalent benefits	Copayments: Tiered copayment structure for enrollees with incomes > 147% FPL and < 318% FPL; copayments range from $100 per year per family for all services to $500 per year per child for hospital services Premiums: Tiered copayment structure for enrollees with incomes > 157% and < 318% FPL; premiums range from $15 per month per child ($40 family max) to $40 per child per month ($80 family max)
MA	Children's Medical Security Plan	Age 18 and younger with income at any level	Limited scope medical benefits (see additional information)	Copayments: Tiered copayment structure for all enrollees; copayments range from $2 to $8 per service per member based on income Premiums: Tiered premium structure for enrollees with incomes ≥ 200% to ≥ 400.1% FPL; premiums range from $7.80 per child per month to $64 per child per month
NY	Child Health Plus	Age 18 and younger with income at any level	Comprehensive medical benefits (see additional information)	Copayments: None Premiums: Tiered premium structure for enrollees with incomes ≥ 160% to ≥ 400% FPL; premiums range from $9 per month per child ($27 family max) to $231 per month per child (no max)

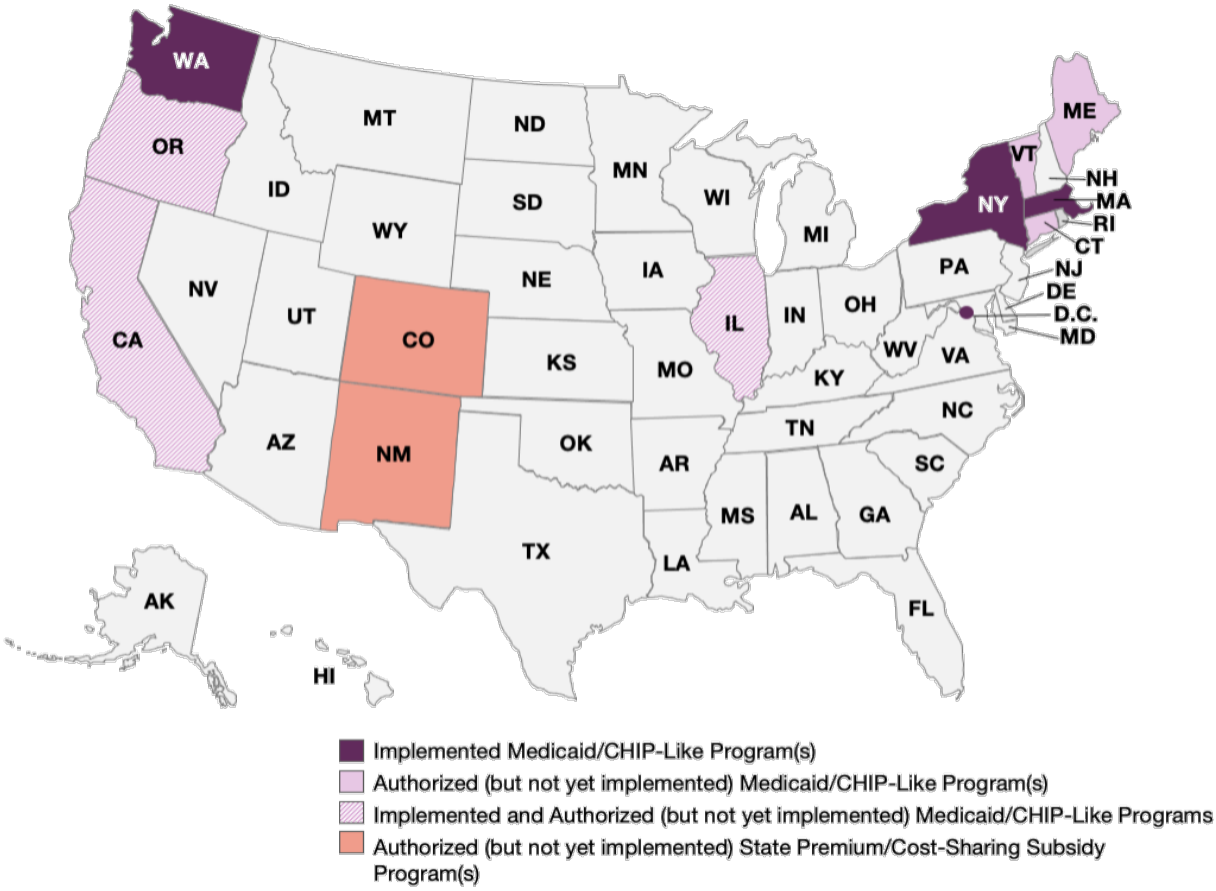
[iv] Table 2 does not include state-sponsored efforts to provide coverage to pregnant/postpartum individuals, nor does it reflect state efforts to establish state-based premium subsidies to purchase individual market coverage for people who are not eligible for ACA, Medicaid, or CHIP coverage.

[v] Both D.C. programs represented in Table 2 are financed with District-only funds.

Table 2: Implemented State-Funded Affordable Coverage Programs for Immigrants[iv]				
State	**Program**	**Eligibility**	**Benefits**	**Cost-Sharing**
OR	Cover All Kids	Age 18 and younger with income < 305% of the FPL	Full scope Medicaid equivalent benefits	Copayments: None Premiums: None
WA	Apple Health for Kids	Age 18 and younger with income ≤ 312% FPL	Full scope Medicaid equivalent benefits	Copayments: None Premiums: Tiered premium structure for enrollees with incomes > 210% and ≤ 312% FPL; premiums range from $20 per month per child ($40 family max) to $30 per month per child ($60 family max)
Immigrant Adults				
CA	Young Adult Expansion	Ages 19 to 25 with income ≤ 138% of the FPL	Full scope Medicaid equivalent benefits	Copayments: None Premiums: None
D.C.	DC Health Care Alliance	Age 21 and older with income ≤ 215% of the FPL; includes an asset test	Limited scope medical benefits (see additional information)	Copayments: None Premiums: None
IL	Health Benefits for Immigrant Seniors	Age 65 and older with income ≤ 100% FPL; includes an asset test	Comprehensive medical benefits (see additional information)	Copayments: None Premiums: None

Other states have established programs at the local level (e.g., Harris County, Texas) to achieve the same aim.[11] Momentum appears to be growing, as a number of other states (e.g., Connecticut,[12] New Jersey,[13] Vermont[14]) have recently enacted state budgets or passed legislation authorizing similar programs (see Figure 1) expected to take effect in 2022 or later. The list of states with recently enacted legislation includes Colorado, which is planning to provide state-based premium subsidies for people who are ineligible for ACA subsidies and Medicaid/CHIP to purchase individual market coverage. Colorado has established through state statute the Health Insurance Affordability Enterprise, which will be funded through a new state health insurance premium tax that replaces the federal health insurance tax in 2021.[15] Part of that funding will be used to create a state-based premium subsidy program that will be available in 2023 to people with incomes up to 300 percent FPL who are ineligible for ACA subsidies, regardless of immigration status. More specifically, the program will be available to qualified individuals (primarily including undocumented individuals and those in the ACA's "family glitch") and designed to meet federal Qualified Health Plan (QHP) requirements.[16]

Figure 1. State Efforts Related to State-Funded Affordable Coverage Programs for Individuals, Regardless of Immigration Status[17]



Notes: Figure 1 reflects comprehensive, affordable coverage programs for individuals, regardless of immigration status.

Generally, state and local policymakers are seeking to advance coverage solutions for immigrants in an effort to cover their remaining uninsured residents, who are disproportionately undocumented people.[18] The benefits of affordable health coverage are undeniable, including improved access to primary and preventive healthcare services, better health outcomes, and higher rates of school and work attendance. Higher health insurance rates in states strengthens the healthcare system by increasing revenue to providers, decreasing uncompensated care costs, and enhancing provider capacity to deliver care.[19] While opponents of state-funded coverage programs cite state spending as a concern, research indicates that health coverage expansions for immigrant populations are ultimately less expensive than providing emergency-only services.[20]

State-Funded Affordable Coverage Programs for Immigrants: Considerations for Policymakers

The design and features of state-funded affordable coverage programs for people who do not qualify for subsidized Marketplace coverage under the ACA or other public programs due to their immigration status vary depending on the makeup of the state's uninsured population, policy objectives, and available resources, among other factors. As noted above, two predominant models that states are relying on to offer access to affordable coverage for immigrant populations that are ineligible for federally funded health coverage are: (1) establishing

state Medicaid/CHIP equivalent or comparable programs (see Table 2); and (2) creating state premium or cost-sharing subsidies to enable individuals to purchase Marketplace coverage. There are a variety of considerations related to opting for one model over the other, including availability of state funding, political and cultural considerations in the state, desire to align coverage to either Medicaid/CHIP or Marketplace coverage, and bandwidth of the state agency (Medicaid program, Department of Insurance, or Marketplace) to implement the program.

We outline below other key program design considerations related to state-funded affordable coverage program development.

Program Costs. Projected program expenditures differ depending on program eligibility (i.e., age and income level), take-up, and, in the case of state programs that mirror Medicaid/CHIP-like benefits, generosity of benefits. California's Health4All Kids, which provides full scope Medicaid equivalent benefits to individuals age 18 and younger, cost about $300 million annually as of 2017.[21] In contrast, Massachusetts's state budget appropriated $15.4 million for the Children's Medical Security Plan that provides healthcare services limited in scope for uninsured children under age 18.[22] As of August 2021, Colorado had budgeted $40 million for its Health Insurance Affordability Enterprise subsidies available to qualified individuals, and estimated that take-up of coverage among undocumented populations would be 25 to 30 percent of the state's total undocumented and uninsured population.[23]

Eligibility and Enrollment. All states implementing state-funded affordable coverage programs for immigrants without access to subsidized health insurance coverage under the ACA or other public programs offer services for children and adolescents. California, Colorado, D.C., Illinois and New Mexico have or are developing initiatives that cover adults. Most states set income eligibility standards for their programs, sometimes paired with asset tests. New York's Child Health Plus program is an exception, providing subsidized health insurance to children under the age of 19 at any income level, regardless of immigration status. To control program costs, some states utilize enrollment caps and waitlists based on available state funding.[24] Colorado is evaluating different eligibility parameters (e.g., first-come first-serve basis, lottery system), and will prioritize certain populations based on eligibility factors in an effort to reduce disparities.[25] Other states have not used these types of levers because enrollment numbers have fallen well short of estimates. For example, Oregon anticipated that 15,000 immigrants age 18 and younger would be eligible for the Cover All Kids program that launched in January 2018. By June 2019, just under 6,000 children were enrolled.[26] To promote the uptake of coverage and prevent disenrollment, states employ various strategies, including automatically transitioning individuals from emergency Medicaid into state-funded coverage (Oregon Cover All Kids approach),[27] automatically enrolling individuals into Medicaid managed care (D.C. Immigrant Children's Program approach),[28] and extending 12 months continuous coverage (Illinois All Kids approach).[29]

Communication and Outreach. Through their efforts to extend coverage to individuals ineligible for federally funded health insurance programs, regardless of immigration status, states have learned that addressing systemic barriers to enrollment requires targeted, community-based outreach paired with investment. Oregon provides a multi-pronged, culturally and linguistically responsive approach to encourage immigrant youth to enroll in Cover All Kids.[30] Efforts included establishing a stakeholder workgroup of diverse community partners that launched a statewide outreach campaign, and investing nearly $2.5 million in funding for community-based organizations (CBOs) to provide outreach, enrollment, and system navigation services. Washington employs community-based enrollment specialists at hospitals, clinical health departments, and community outreach centers,[31] and Illinois refers adult enrollees to Protecting Immigrant Families and Immigrant Family Resources to answer enrollment questions.[32] Efforts such as these are particularly important in light of enrollment barriers and reluctance to engage with the state for fear about the potential impact on immigration status.

Cost-Sharing. Among the states with Medicaid/CHIP equivalent or comparable state-funded affordable coverage programs that impose copayments and/or premiums, most use a tiered structure based on household income and family size. New York's program has premiums that range from $9 per month per child for those with incomes between 160 and 221 percent of the FPL, to $231 per child per month for those with incomes 400 percent of the FPL or greater.[33] For administrative simplicity, California has aligned its Health4AllKids premium structure with that

of its Medicaid program.[34] A few states do not require cost-sharing in their programs at all. Colorado is evaluating the subsidy structure for its program, considering subsidizing monthly premiums costs to incentivize enrollment (premium wrap) or reducing out-of-pocket costs [Cost Sharing Reduction (CSR)]. Per state legislation, the lowest income individuals will have no premiums and be provided benefits actuarially equivalent to 90 percent of the full actuarial value of benefits provided under the program.[35] While cost-sharing creates hurdles to equitable health coverage for low-income individuals, imposing copayments and premiums on higher income enrollees may be appropriate (e.g., for people with incomes above 400 percent of the FPL in states that do not have income limits). Notably, states are unlikely to offset program costs through cost-sharing requirements on low-income populations. Research indicates that potential revenue gains are offset by enrollment churn, increased utilization of costly services, and administrative expenses.[36]

Benefits. In an effort to ensure access to comprehensive health coverage for all, several states align benefits in state-funded affordable coverage programs for immigrants to their Medicaid state plan benefits. Other states limit the scope of benefits in these programs (e.g., to primary care, preventive services) and/or impose service limits (e.g., dental care up to $1,000 per year, up to 20 behavioral health outpatient visits per year). In the case of states pursuing state premium subsidy programs, individuals will likely have access to individual market coverage that provides access to Essential Health Benefits (EHBs), though states can opt to provide less robust (and therefore less costly) coverage that does not meet ACA QHP standards.[vi] In other words, state-subsidized health coverage is not required to cover ACA-mandated EHBs or be certified as a QHP.

Financing. The influx of federal stimulus dollars, and American Rescue Plan Act (ARP) funding in particular, has provided substantial relief to state budgets, likely contributing to lawmakers' ability to finance and garner support for state-funded affordable coverage programs. States standing up coverage for their residents without access to subsidized coverage due to their immigration status, are financing these programs using state general funds, including funds generated through health insurance premium taxes (Colorado and New Mexico), other provider taxes, tobacco taxes and disease management program savings.[37] States such as Massachusetts have elected to carve emergency services out of their Medicaid/CHIP-based state-funded benefit packages to ensure they maximize federal matching funds for emergency Medicaid.[38] In practice, enrollees retain coverage for emergency services, and the state-funded program serves as a supplemental or wrap-around benefit. California has undertaken a creative approach and is planning to provide full scope Medicaid equivalent benefits (including emergency services) in its Young Adult Expansion, but will seek to recoup from the Centers for Medicare & Medicaid Services (CMS) federal funds that would have otherwise been provided for emergency Medicaid.[39]

Conclusion

Extending state-funded coverage to low-income children and adults who do not qualify for subsidized health insurance under the ACA or through Medicaid/CHIP due to their immigration status has long been a strategy available to states, and the significant burden that COVID-19 has placed on immigrant populations has catalyzed further action. As the immigrant population grows at a rapid pace, states have an imperative to address persisting structural racism that impacts the health of immigrants by closing the gap in coverage and better integrating immigrant families into the healthcare system. Absent new federal statutory or policy options for covering immigrant populations, this momentum is likely to continue as states take it upon themselves to implement state-funded affordable coverage programs for their remaining uninsured residents, regardless of their immigration status.

[vi] EHBs are a set of 10 categories of services that Marketplace plans are required to cover under the ACA. EHBs are minimum requirements, so plans may offer additional benefits, such as dental and vision on top of the required services.

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This issue brief was prepared by Kaylee O'Connor, Max Blumenthal, Patricia Boozang, and Linda Elam. Manatt Health integrates legal and consulting expertise to better serve the complex needs of clients across the healthcare system. Our diverse team of more than 160 attorneys and consultants from Manatt, Phelps & Phillips, LLP and its consulting subsidiary, Manatt Health Strategies, LLC, is passionate about helping our clients advance their business interests, fulfill their missions, and lead healthcare into the future. For more information, visit *https://www.manatt.com/Health*.

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