State Initiatives to Expand Coverage and Access to Care for Undocumented Immigrants

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THE PROBLEM

Approximately 10.5 million undocumented immigrants currently reside in the United States, representing 3.2 percent of the total U.S. population. They either entered the country without authorization or hold expired visas. Although they may have lived in the U.S. for years and are contributing to the economy, the majority of undocumented immigrants are barred from accessing federally funded public health insurance programs.[1,2]

For example, with the exception of emergency Medicaid benefits,[3] the Personal Responsibility and Work Reconciliation Act of 1996 (also known as welfare reform) greatly restricted undocumented immigrants from enrolling in Medicare, Medicaid and the Children's Health Insurance Program. The Affordable Care Act of 2010 (ACA) codified the existing exclusion policies to include state and federal marketplaces prohibiting undocumented immigrants (including Deferred Action for Childhood Arrivals (DACA) recipients[4]) from both receiving federal financial assistance (i.e., premium tax credits and cost-sharing subsidies) and purchasing qualified health plans at full price. As a result, the uninsurance rate of undocumented immigrants is nearly five times higher than that of citizens. In 2017, half of undocumented adults and one-third of undocumented children were uninsured.[5]

Since most can't afford to buy private insurance in the individual market, undocumented immigrants rely on no-fee or low-fee care provided at community health centers and by a patchwork of hospital financial assistance policies. Additionally, in the past few years, due to increasing threats of detention and deportation, many undocumented immigrants have gone entirely without health care to avoid running afoul of immigration authorities.[6]

Despite the challenging coverage and access environment, and in recognition of the significant contribution of undocumented immigrants to state and local economies, several states and localities are forging ahead with innovative solutions for this population – working to ensure that their health care needs are met.

This brief will:

- highlight a number of existing programs initiated at the state and local levels;
- discuss additional policy options some states have been exploring; and
- offer key takeaways for advocates to consider before embarking on a campaign to expand coverage to undocumented immigrants.

EXISTING INITIATIVES TO ENSURE COVERAGE AND ACCESS TO CARE FOR UNDOCUMENTED IMMIGRANTS

This section highlights state and local initiatives to expand health insurance coverage and ensure access to primary care and vital services (such as prenatal care) for the most vulnerable members of this population.

1) USING STATE OR COUNTY/CITY-ONLY FUNDS TO ESTABLISH MEDICAL HOME PROGRAMS

Some states and localities have established programs to ensure access to medical homes for undocumented immigrants. Depending upon available funding and local priorities, these medical-home programs vary significantly in terms of services covered, income eligibility standards and cost-sharing, and some programs cap enrollment. For instance:

California: In February 2019, the County Medical Services Program (CMSP) launched a two-year pilot project, called Path to Health Project, to provide free primary care services for 25,000 undocumented immigrant adults between the ages of 21 and 64. Except for emergency care, beneficiaries receive care at assigned clinic organizations. There is a $5 copay

prescription at in-network pharmacies. While CMSP is a state-funded program, many of the 35 counties participating in the program provide access to undocumented immigrants through the Path to Health Project with their own county-level funds.[7]

Massachusetts: The Health Safety Net (HSN), was created as part of Massachusetts' health reform to help pay providers for health services for uninsured and underinsured residents whose income is below 300% of the Federal Poverty Level (FPL), regardless of their immigration status. Beneficiaries receive medically necessary services (such as doctor visits, emergency services, mental health services) at community health centers and hospitals. Individuals with full HSN benefits (income below 150% FPL) only pay small copayments for prescription medications. Individuals with partial HSN benefits (income between 150-300% FPL) are responsible for a sliding scale annual deductible.[8] The HSN is funded through an assessment on hospitals and health insurance carriers. The state can claim federal reimbursement for HSN payments to providers who treat non-Medicaid-eligible, uninsured individuals under the State's Medicaid 1115 waiver demonstration.[9]

New York: In early 2019, New York City launched the NYC Care, to provide medical homes for an estimated 600,000 of its residents who are currently ineligible for health insurance, half of whom are undocumented immigrants. NYC Care (financed out of the city's $1.6 billion-per-year Department of Public Health and Mental Hygiene budget) assigns a primary care doctor to each beneficiary and helps patients find specialists if needed.[10] Health care services are available at a discount rate based on household size and income. With an estimated cost of $100 million per year, NYC Care was expected to expand across all five boroughs by the end of 2020. As part of the initiative, the City will partner with community-based organizations to reach its residents eligible to participate in the program.[11]

2) LEVERAGING FEDERAL FUNDS TO PROVIDE VITAL SERVICES TO TARGETED MEMBERS OF UNDOCUMENTED IMMIGRANT COMMUNITIES

Sixteen states (Arkansas, California, Illinois, Louisiana, Massachusetts, Michigan, Minnesota, Missouri, Nebraska, Oklahoma, Oregon, Rhode Island, Tennessee, Texas, Washington and Wisconsin) have taken the Immigrant Children's Health Improvement Act (ICHIA) option leveraging federal funds to provide prenatal care to undocumented pregnant immigrant people. In some states, this policy intervention is framed as providing benefits to the "unborn child." This means fetuses (not pregnant people) are considered CHIP-eligible beneficiaries who have a functional personhood status, thus have rights to health care. This framing of the benefit as adhering to a fetus instead of a pregnant person is highly problematic from a reproductive rights standpoint.[12] Advocates should keep in mind that anti-choice lawmakers may be more inclined to support this policy initiative with the understanding that it could then provide them a pathway for the passage of anti-choice legislation.

Other states, such as New Jersey, New York and the District of Columbia, have used state-only funds to provide the full scope of Medicaid benefits to undocumented immigrant women during their pregnancy and through three months postpartum. However, New Jersey offers this program only as a block grant program; this means enrollment ends once the funding appropriated by the legislature has been exhausted.[13]

In 2019, Washington enacted a two-year state budget to expand the Family Planning Only Program (FPO) to the state's uninsured residents at reproductive age with income up to 260 percent of the federal poverty line. Beginning January 2020, approximately 240,000 people who are undocumented or who are subject to the five-year waiting period were able to access to essential reproductive health care services.

3) USING STATE FUNDS TO EXPAND MEDICAID COVERAGE TO LOW-INCOME UNDOCUMENTED IMMIGRANTS

Many states have taken incremental steps to expand public health insurance coverage to low-income undocumented immigrants. For instance, six states (California, Illinois, Massachusetts, New York, Oregon and Washington) and the District of Columbia have expanded Medicaid coverage to low-income children up to the age of 18 and to pregnant people regardless of immigration status, and they continue to look for additional ways to expand coverage to adults.

In 2016, California successfully expanded Medi-Cal (its Medicaid program) to all children with income up to 266% FPL. In 2019, California passed legislation that included an investment to cover approximately 90,000 low-income undocumented immigrants through age 25.[14] At full implementation, this program will include 135,000 young adults. California continues to leverage emergency Medicaid funds to offset the cost of expansion. As federal law allows state reimbursement for emergency hospitalizations and labor and delivery services provided to undocumented immigrants, California officials are planning to recoup federal emergency Medicaid dollars for those services (nearly $24 million in the first year, which is about a quarter of the expansion cost) and use state funds for other Medi-Cal benefits (such as preventive and primary care, prescription drugs and hospitalizations).[15]

In 2020, as COVID-19 disproportionately harms communities of color in Illinois, the state signed the Fiscal Year 2021 budget that extends Medicaid-like insurance coverage to low-income immigrant seniors regardless of their immigration status. Prior to the bill's passage, the program was expected to benefit up to 1,000 people who are undocumented or who are subject to the five-year waiting period. However, as a result of a successful outreach and enrollment campaign and the pent-up need among older adult immigrants who have never had health care before, more than 4,257 seniors have enrolled.[16]

ADDITIONAL POLICY IDEAS FOR CONSIDERATION

This section explores three additional ideas that have been discussed among policy experts and consumer health advocates: (1) require non-profit hospitals to make financial assistance programs (aka charity care) available to undocumented immigrants; (2) allow undocumented immigrants to buy into Basic Health Plans (BHPs); (3) allow undocumented immigrants to buy into Medicaid; and (4) offer Bronze-level-like plans to supplement existing emergency Medicaid benefits for low-income undocumented immigrants. While option 1 depends on specific hospital initiatives, options 2, 3 and 4 require state-based actions and rely heavily on the state's general revenue (though states can leverage all types of available financing – emergency Medicaid funds, as well as provider and insurer assessments – to offset the cost of expansion).

1) REQUIRE NON-PROFIT HOSPITALS TO MAKE FINANCIAL ASSISTANCE PROGRAMS (AKA CHARITY CARE) AVAILABLE TO UNDOCUMENTED IMMIGRANTS

Under the ACA, non-profit hospitals are required to partner with community and public health representatives to identify and develop strategies for addressing community health needs. Whether by investing in affordable housing and food security, subsidizing health clinics or offering financial assistance to people who would otherwise be priced out of care, hospitals can be powerful allies in the fight to end health and economic injustice. Since hospitals have a lot of latitude in terms of how they structure these programs, states can provide guidance to hospitals encouraging them to provide free or low-cost care to undocumented immigrants under their financial assistance programs.

2) ALLOW UNDOCUMENTED IMMIGRANTS TO BUY INTO BASIC HEALTH PLANS (BHPS)

The Basic Health Plan (BHP) is a state-administered option under the ACA for (a) adults earning just above Medicaid eligibility level but less than 200% of FPL, and (b) legally present immigrants earning under the Medicaid eligibility level but who do not qualify for Medicaid because of their immigration status. If a state chooses to take up the BHP option, the federal government will give that state 95% of the money it would have spent on subsidies for this population in the ACA marketplace. To proceed, states must submit a BHP's blueprint under the ACA's section 1331.[17] By doing so, states are able to leverage federal funds to improve affordability for people with moderate income who still struggle to buy marketplace coverage due to cost.

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After establishing BHPs, states could allow all undocumented immigrants to buy into BHPs without federal subsidies. To address affordability issues, states would need to use state-only funds to provide financial assistance for those with incomes below 200% of FPF. States could select one of the two options shown in the table below:

OPTION 1: THIS OPTION IS AVAILABLE TO ANY STATE	**Undocumented immigrants with all income levels: Sliding scale buy-in to BHP coverage**	
OPTION 2: THIS OPTION REQUIRES STATES TO EXPAND MEDICAID COVERAGE TO LOW-INCOME UNDOCUMENTED IMMIGRANTS	**Income below 138% of FPL: Eligible for Medicaid coverage at full cost to the state**	**Income above 138% of FPL: Sliding scale buy-in to BHP coverage**

3) ALLOWING UNDOCUMENTED IMMIGRANTS TO BUY INTO MEDICAID

If a state looks for ways to expand coverage for undocumented immigrants while at the same time improving affordability for others, Medicaid buy-in is considered the most suitable option.[18] A number of advantages include:

- There is no requirement for federal approval to establish Medicaid buy-in.
- This option would have minimal impact on the state's ACA marketplace because of its primary targets – which are (1) uninsured populations due to their immigration status; and (2) individuals enrolled in insurance plans that are outside the marketplace who are looking for more affordable unsubsidized options.

Under this option, the benefit package would be similar to Medicaid benefits. The targeted populations would be required to pay the full cost of the premium and cost-sharing associated with coverage. However, to address affordability issues, states could appropriate state funds to provide sliding scale premium and cost-sharing assistance based on income.

4) OFFERING LOW-INCOME UNDOCUMENTED IMMIGRANTS BRONZE-LIKE PLANS TO SUPPLEMENT EXISTING EMERGENCY MEDICAID BENEFITS

This option was discussed among policy experts and advocates in New York. If selecting this policy, states would use state funds to purchase bronze-like coverage in the individual market to supplement emergency Medicaid benefits for low-income undocumented immigrants.[19] For emergency hospitalizations and labor and delivery services, states would leverage federal emergency Medicaid funds.

However, there could be affordability issues with this path. Although enrollees would have no monthly premiums, they would be responsible for deductibles and coinsurance (after deductibles are met) for non-preventive care. According to the Kaiser Family Foundation, deductibles and coinsurance are typically high – the average for bronze plans in 2019 was more than $6,000 per individual.[20]

KEY ISSUES FOR CONSIDERATION

1) POLICY CONSIDERATIONS

Don't write off incremental progress – The path to gaining coverage and care for undocumented immigrants is not easy. Advocates working on these campaigns have quickly learned to be flexible and consider all options for success. While the goal of health care for all regardless of immigration status remains unchanged, many campaigns to expand coverage and care options to undocumented immigrants across the country start by moving slowly and incrementally. In other words, starting at the city and county levels first by establishing medical homes, then moving to statewide by offering vital health care services for a specific population, or comprehensive coverage expansion for certain age groups. A common strategy used in many states has been starting with coverage expansion for undocumented immigrant children. There is mutual understanding that expanding coverage to all kids is a win-win for children and states. For the public, people know that supporting all kids means improving their health today and into the future. For states, investing in children means nurturing the future workforce as taxpayers.[21]

Ensure coverage expansion is fiscally sound – Keep in mind coverage expansion costs money and one of the persistent challenges is how to fund such initiatives. While some policymakers might be willing to step up to champion the effort, others might prioritize funding other budget interests. To help policymakers have confidence in this effort, advocates should carefully quantify the costs and benefits of the expansion for this new population and get fiscal notes as accurate as possible. It is helpful to collect and analyze data on how undocumented immigrants currently access health care services at the local and state level and how much these services cost over time.

As mentioned above, some localities have already expanded coverage and care for this population. Advocates should prioritize monitoring and evaluating the outcomes of these demonstrations and make the case for larger expansion. Secondly, it is critical that advocates work closely with policymakers to identify all types of available financing to fund such initiatives. Those may include federal emergency Medicaid funds, provider assessments, raising additional revenues through tax increases (such as tobacco tax and sugar-sweetened beverage tax), though each of these approaches has advantages and disadvantages. Finally, be prepared for economic recession, which can make the political climate more inhospitable to coverage expansion; but for undocumented immigrants in particular, because this population would be the first targeted for cuts. Advocates should continuously nurture and maintain coalitions to quickly mobilize against funding cuts.

Ensure affordability for all – One of the big political challenges is that coverage for undocumented immigrants could be pitted against coverage for citizens – particularly low-income adults in non-Medicaid expansion states and adults (especially those over 50 years old) with income above 400% of FPL who are facing very high premiums. Advocates may want to consider programs that simultaneously expand affordability for multiple populations which may be easier to pass than policies that focus exclusively on undocumented immigrants.

2) IMPLEMENTATION CONSIDERATIONS

Be aware of federal sabotage – In addition to the attacks on immigrant families that took place throughout the duration of the Trump administration, Republicans in Congress are still finding ways to scrutinize states' use of federal funds to cover undocumented immigrants. For instance, in 2019, the Protect Medicaid Act (S. 131) was introduced by six Republican senators seeking to prohibit federal payment under Medicaid for the administrative costs of providing health benefits to noncitizens who are ineligible for Medicaid based on their immigration status.[22] For those states leveraging federal emergency Medicaid funds to pay part of the expansion costs to cover undocumented immigrants, while this approach is legal, they could face federal scrutiny.

Invest in outreach and enrollment – Research shows that shifting immigration policies (such as public charge and deportation) under the Trump administration have substantially incited fear in immigrant communities, causing people to dis-enroll from public programs or forgo medical care.[23] It is more critical than ever that states invest in robust outreach,

education and enrollment programs and strengthen community workforce. Continued investment and integration of direct service partners (like community health workers and community-based navigators and assisters) is a way to engage with community members. At the same time, these community partners can help states relay accurate and in-language information on enrollment and coverage retention and utilization as well as information about immigrant rights regarding privacy of health coverage information and immigration enforcement.

3) ADVOCACY CONSIDERATIONS

Cultivate political leadership and public support – Commitments from critical leadership in both the state administration and legislature are an important component to expanding coverage and access for undocumented immigrant campaigns. As mentioned above, carefully conducting data analysis on the costs and benefits of the expansion is one way to help build confidence and cultivate political leadership. Additionally, advocates should develop messages that directly address the unique needs of their state's residents and the state's health care system in order to harness public support.

Maintain broad and diverse coalitions – Strong coalitions and networks contribute greatly to advocacy efforts. Evidence shows, in all successful campaigns, faith-based groups, immigration advocates, consumer health advocacy groups and community-based organizations) have played a central role to the success in keeping the issue alive and getting it to the finish line. In addition, having all the stakeholders at the table (providers, business communities, organized labor, and insurers) is vital to reaching agreements with broad public support. However, keep in mind that there are some potential pitfalls when working to balance between the mission of immigrant rights groups and what motivates decision makers to commit to these efforts. For instance, some policymakers might be open to the policy that allows undocumented immigrants to buy health insurance coverage on the ACA marketplace at full cost but would not want to commit to making them eligible to obtain premium tax credits and cost-sharing reductions – one of the policies immigrant right groups are advocating for.

Build winning messages about the importance of expanding coverage for undocumented immigrants.

Advocates working on coverage expansion for undocumented immigrants have found that messages that effectively unite the public to support this cause are those focusing on moving everyone forward – such as health care for all or cover all kids. At the same time, they have found that it is important to elevate the valuable contributions of undocumented immigrants to both the state and local economy. Sympathetic individual immigrant stories are key. It is important to ensure immigrants' voice and their value are reflected at the negotiation table. Finally, don't forget to develop different messages that target specific audiences. As mentioned above, many policymakers often have concerns over costs. Thus, messages that target this audience should focus on workable solutions and cost-efficiency for their state health care system.

CONCLUSION

In the absence of federal inclusion policies to ensure the health care needs of undocumented immigrants are met, many states have stepped up to fill the gap. Depending upon their political environment and fiscal feasibility, some states have selected small steps at the local level, while others have pursued statewide coverage expansion. Consumer health advocates and their diverse partners have played a powerful role in keeping the issue alive and moving their campaigns toward universal coverage for all regardless of immigration status.

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SUMMARY CHART: EXISTING STATE INITIATIVES

ESTABLISHING MEDICAL HOME PROGRAMS

SELECTED EXAMPLES	FUNDING SOURCES	BENEFICIARIES	BENEFITS/ COST-SHARING	CAVEATS
CA - CMSP's Path to Health project	County funds	Undocumented immigrant adults ages 21 and older who are enrolled in restricted scope Medi-Cal and are residing in 35 CMSP counties.	Primary care	Scope of these programs (i.e. enrollment, eligibility standard, benefit package, and premiums and cost-sharing standards) are determined by local priorities and availability of resources
MA - Health Safety Net (HSN)	State funds *Possibility to receive federal reimbursement for uncompensated care under MassHealth Medicaid 1115 waiver demonstration	Uninsured and underinsured residents regardless of immigration status and with income below 400% of FPL	Certain medically necessary services provided at acute care hospitals and community health centers Sliding scale copayment	
NY - New York City Care (NYC Care)	City funds	Uninsured and underinsured residents regardless of immigration status	Primary and preventive care services Sliding scale fee-for-service	

ESTABLISHING MEDICAL HOME PROGRAMS

STATES	FUNDING SOURCES	BENEFICIARIES	BENEFITS/ COST-SHARING	CAVEATS
16 states (AR, CA, IL, LA, MA, MI, MN, MO, NE, OK, OR, RI, TN, TX, WA, WI)	Federal funds through CHIP - ICHIA option	Low-income eligible undocumented immigrant women during pregnancy	Prenatal care & services for conditions that could complicate pregnancy	Some states framed this policy option as the "unborn child" option. This means fetuses (not pregnant women) are awarded as CHIP-eligible beneficiaries. Advocacy groups working on reproductive health and rights are opposed to this policy position.
2 states (NJ & NY) and DC *NJ offers this program as a block grant program	State funds	Low-income eligible undocumented women during pregnancy and for 3 months after birth	Full scope of Medicaid benefits	Limited duration of coverage

SUMMARY CHART: EXISTING STATE INITIATIVES

EXPANDING MEDICAID COVERAGE FOR ALL LOW-INCOME IMMIGRANTS WHO ARE CURRENTLY INELIGIBLE FOR THE PROGRAM

STATES	FUNDING SOURCES	BENEFICIARIES	BENEFITS/ COST-SHARING	CAVEATS
6 states (CA, IL, MA, NY, OR, WA) and DC	State funds *Possibility to leverage emergency Medicaid funds	Low-income immigrant children up to 19 years old regardless of immigration status (including undocumented immigrants and immigrants with DACA, COFA and PRUCOL statuses)	Full scope of Medicaid benefits	If using federal Medicaid emergency funds, states are responsible for submitting sufficient evidence (to CMS satisfaction) that those dollars are only paid for emergency services
1 state: CA	State funds Emergency Medicaid funds *Possibility to leverage emergency Medicaid funds	Low-income eligible undocumented immigrant children between the ages of 19 and 25 years old	Full scope of Medicaid benefits	As above
1 state: IL	State funds *Possibility to leverage emergency Medicaid funds	Low-income immigrant seniors at age 65 and above how are undocumented or legally reside in Illinois less than 5 years.	Full scope of Medicaid benefits	As above

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3) Under the 1986 Emergency Medical Treatment and Active Labor Act (EMTALA), hospital Emergency Departments that accept payments from Medicare are required to provide an appropriate medical examination and stabilization to anyone seeking treatment for a medical condition, regardless of citizenship, legal status, or ability to pay. https://www.cms.gov/regulations-and-guidance/legislation/emtala/ Accessed September 5, 2019.

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17) 42 CFR § 600.110 - BHP Blueprint https://www.law.cornell.edu/cfr/text/42/600.110. Accessed November 4, 2019

18) In 2019, New Mexico considered the Medicaid buy-in option (HB 416 and SB 405) to expand coverage for the state's uninsured residents due to immigration status and improve affordability for individuals who are ineligible for subsidized coverage in the marketplace. Unfortunately, legislation did not pass.

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