

Policy Solutions to Improving Access to Coverage for Immigrants

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Family Planning
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Policy Solutions to Improving Access to Coverage for Immigrants

Immigrants in the United States face longstanding health disparities, which are largely driven by challenges accessing health coverage and care. These circumstances have been shaped by factors that include immigration status, limited English proficiency, socioeconomic background, geography, and stigma and marginalization.¹ Consequently, immigrant women, whether lawfully present or undocumented, are disproportionately at risk of negative reproductive, sexual, and maternal health outcomes when compared to the general population.² For example, immigrant women disproportionately experience higher rates of cervical cancer and related deaths than US-born women.³ As an organization committed to reproductive health access and freedom for all, the National Family Planning & Reproductive Health Association (NFPFRA) strongly advocates for policies at all levels of government that improve access to health care coverage and high-quality care, including family planning and sexual health services. The following paper highlights policy opportunities to expand immigrant access to health coverage as an approach to help mitigate existing health disparities.

Barriers to Coverage

Since the 1990s the federal government has created barriers that substantially limit immigrants' access to health coverage. Prior to the 1996 enactment of the Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA), lawfully present immigrants mostly had equal access to public assistance benefits, including safety-net coverage through Medicaid, and states could not restrict access to federal programs on the basis of citizenship status.⁴ However, PRWORA redefined the criteria for "qualified immigrant,"⁵

barring access to federal assistance for those who do not meet this criteria, and delaying access for qualified immigrants who entered the country after 1996 for five years.⁶ Furthermore, upon the enactment of the Deficit Reduction Act (DRA) in 2006, proof of citizenship became a requirement for Medicaid enrollment. Previously, individuals could attest, under the penalty of perjury, to their citizenship status in writing. The DRA was intended to reduce Medicaid spending and by the belief that Medicaid enrollees included undocumented and lawfully present immigrants who had

yet to complete the waiting period. Later evidence has shown that the DRA has unintentionally excluded eligible enrollees because the requirement was onerous and burdensome, leading to eligible individuals delaying or dropping their coverage rather than fulfill the requirement. Furthermore, the estimated number of ineligible Medicaid enrollees was less prevalent than expected, suggesting the law's motivations were overstated.⁷

These statutory restrictions are enhanced by immigrants' over-representation in

1 Kathryn Pitkin Derosé, José J. Escarce, and Nicole Lurie, *Immigrants and Health Care: Sources Of Vulnerability*, accessed May 31, 2016, <http://content.healthaffairs.org/content/26/5/1258.full#ref-1>.

2 Kinsey Hasstedt, "The Case for Advancing Access to Health Coverage and Care for Immigrant Women and Families," *Health Affairs (Blog)*, November 19, 2014, <http://healthaffairs.org/blog/2014/11/19/the-case-for-advancing-access-to-health-coverage-and-care-for-immigrant-women-and-families/>.

3 *Ibid.*

4 Audrey Singer, *Welfare Reform and Immigrants: A Policy Review*, accessed May 31, 2016, http://www.brookings.edu/~media/research/files/reports/2004/5/demographics%20singer/200405_singer.pdf.

5 Qualified immigrants include lawfully permanent residents, asylees, refugees, immigrants paroled into the U.S. for at least one year, immigrants whose deportations are being withheld, immigrants granted conditional entry, battered children and spouses, Cuban and Haitian entrants, and trafficking victims.

6 "Summary of Immigrant Eligibility Restrictions Under Current Law," Office of the Assistant Secretary for Planning and Evaluation, last modified 2009, <http://aspe.hhs.gov/basic-report/summary-immigrant-eligibility-restrictions-under-current-law>.

7 United States Government Accountability Office, *Medicaid: States Reported That Citizenship Documentation Requirement Resulted in Enrollment Declines for Eligible Citizens and Posed Administrative Burdens*, accessed May 31, 2016, <http://www.gao.gov/new.items/d07889.pdf>.

8 Patient Protection and Affordable Care Act, 42 U.S.C. § 18001 (2010).

low-wage jobs that provide limited access to employer-sponsored health insurance. While lawfully present immigrants are able to access coverage through the marketplaces, the Affordable Care Act (ACA) excludes undocumented immigrants from purchasing affordable health insurance in the marketplace.⁸ Subsequently, Deferred Action for Childhood Arrivals (DACA) recipients were also excluded from health coverage options available in the health insurance marketplaces when the definition of lawfully present immigrants was changed, essentially classifying them as undocumented.^{9,10}

Regardless, federal and state policymakers have increasingly recognized the importance of and financial benefits that occur from expanding access to health care coverage. Accordingly, a number of policy options to expand coverage have been created in the last ten to 15 years from which immigrants can benefit. The following highlights state and local programs that are designed to expand access to health coverage for immigrants, as well as opportunities for states to increase coverage in partnership with the federal government.

Policy Solutions: State Options

Basic Health Plan

*The ACA grants states the option to cover low-income residents through basic health plans outside of the health insurance marketplace. Similar to marketplace plans, a basic health plan must cover the ten categories of essential health benefits required by the ACA.*¹¹ As of December 2015, Minnesota and New York had established basic health plans.¹² Eligible individuals must be under 65, ineligible for Medicaid, and have not been offered employer-sponsored coverage that is deemed affordable under the ACA. Individuals must also have incomes between 138% and 200% of the federal poverty level (FPL). While undocumented immigrants are ineligible, lawfully present immigrants who have fulfilled the five-year waiting period and meet the income requirements are eligible. Additionally, those who have yet to complete the waiting period are eligible if their incomes are below 138% FPL.¹³ Had they participated in the marketplace, these individuals would have been eligible for premium tax credits and cost-sharing reductions, but may have still found the cost to be prohibitive even with the subsidies. Should they choose to participate in the lower cost basic health plan, the federal government will pay 95% of what the enrollee would

have received in premium tax credits and cost-sharing reductions had they participated in the marketplace.¹⁴ The basic health plan provides an alternative to qualified health plans for enrollees at a lower cost, but with comparable coverage. Prior to establishing basic health plans, both Minnesota and New York already covered lawfully permanent immigrants not yet eligible for Medicaid with state funds. Other states who have previously made this decision would be able to free up state funds by moving toward the basic health plan option.¹⁵

Expanding Coverage for Pregnant Women and Children through CHIP and Medicaid

*Following reauthorization of the Children's Health Insurance Program (CHIP) in 2009, states got an option, known as the Legal Immigrant Children's Health Improvement Act (ICHIA), to enroll lawfully present immigrant pregnant women and children in Medicaid and CHIP, with federal funds. These groups were cut off from immediate eligibility in 1996 when welfare reform was passed, due to the five-year bar to public benefit programs for qualified immigrants.*¹⁶ So far, 31 states have elected to take this

9 DACA recipients were already ineligible for full-scope Medicaid and CHIP because individuals with deferred action status are not considered qualified immigrants. However, deferred action recipients not participating in DACA are eligible to participate in the health insurance marketplace.

10 "Pre-Existing Condition Insurance Plan Program." *Federal Register* 45:152 (August 30, 2012) p. 52614.

11 The essential health benefits consist of outpatient care, emergency room visits, inpatient care, pre and postnatal care, mental health and substance use disorder services, prescription drugs, rehabilitative services and devices, laboratory devices, preventive services, and pediatric services, which includes dental and vision care.

"10 health care benefits covered in the Health Insurance Marketplace," *HealthCare.gov blog*, <https://www.healthcare.gov/blog/10-health-care-benefits-covered-in-the-health-insurance-marketplace/>.

12 "Basic Health Program," *Medicaid.gov*, accessed May 31, 2016, <https://www.medicaid.gov/basic-health-program/basic-health-program.html>.

13 Amanda Cassidy, "Health Policy Brief: Basic Health Program." *Health Affairs* 80 (November 2012). http://healthaffairs.org/healthpolicybriefs/brief_pdfs/healthpolicybrief_80.pdf.

14 *Ibid*.

15 Cheryl Fish-Parcham, "Why Minnesota and New York Are Pursuing Basic Health Programs," *Families USA (blog)*, November 18, 2014, <http://familiesusa.org/blog/2014/11/why-minnesota-and-new-york-are-considering-basic-health-programs>.

16 Mara Youdelman, Q&A: *The Legal Immigrant Children's Health Improvement Act*, accessed May 31, 2016, <http://www.healthlaw.org/publications/qa-on-ichia-the-legal-immigrant-childrens-health-improvement-act#.Vngvf36rSUK>.

option for children up to age 19, and of the 31, 22 have also taken the option for pregnant women.^{17,18} Health coverage for the minor dependent lasts as long as they continue to meet other eligibility requirements. And while ICHIA only provides full scope Medicaid coverage to pregnant women and subsequently up to 60 days postpartum,¹⁹ the benefit allows for auto-enrollment for their children in Medicaid or CHIP for their first year of life.²⁰ It should be noted that the states

that have taken the ICHIA option are diverse geographically, demographically, and politically.

Another more limited coverage option for pregnant women has been made available through CHIP for states that do not take up the ICHIA option. In 2002, CHIP regulations were modified to allow states to cover prenatal care for the pregnant woman regardless of her immigration status. This allows states to use federal

funding to cover only services related to pregnancy or any complications that might complicate the pregnancy.²¹ Fifteen states have taken up this option.²² Health equity advocates, including groups such as the National Latina Institute for Reproductive Health, oppose this policy because the underlying the conferral of prenatal and maternity coverage is the notion that fetuses are functionally awarded personhood status and therefore rights to health care through the policy.²³

Policy Solutions: State Programs

A number of states and counties offer programs and coverage options that are designed to expand health coverage to immigrant populations; some provide comprehensive coverage while others provide limited coverage, such as mental health, dental care, immunizations, maternal health, prenatal care, and cancer screenings. In addition, a number of states have programs for children up to 19 with varying immigrant statuses,²⁴ and some states, cities, and counties also provide coverage through indigent

or charity care programs, regardless of an applicant's immigration status. For example, under New York state law, uninsured, undocumented immigrants are entitled to receive financial assistance at both public and private hospitals, making non-emergency care more affordable.²⁵ Fourteen states as well as the District of Columbia (DC) use state funds to provide public insurance to qualified immigrants currently barred from Medicaid and CHIP under the five-year bar. In addition, 16 states and DC use state funds to

cover select categories of non-qualified immigrants.²⁶ Also, five states and DC provide public health insurance to all deferred action recipients who meet income-eligibility requirements.²⁷ Some states for instance use the benefit eligibility category "permanently residing in the US under color of law" (PRUCOL) to determine eligibility for public programs. PRUCOLs are generally individuals that the government is aware of but do not plan to deport or remove from the country.²⁸ New York's constitution requires

17 Wyoming covers lawfully present pregnant women but not children.

18 "Medicaid/CHIP Coverage of Lawfully-Residing Immigrant Children and Pregnant Women," Kaiser Family Foundation, last modified January 1, 2016, <http://kff.org/health-reform/state-indicator/medicaid-chip-coverage-of-lawfully-residing-immigrant-children-and-pregnant-women/>; National Immigration Law Center, *Medical Assistance Programs for Immigrants in Various States*, accessed May 31, 2016, <https://www.nilc.org/wp-content/uploads/2015/11/med-services-for-imms-in-states.pdf>.

19 Laura Parisi and Rachel Klein, *Covering Pregnant Women: CHIPRA Offers a New Option*, accessed May 31, 2016, http://familiesusa.org/sites/default/files/product_documents/Covering-Pregnant-Women.pdf.

20 *Ibid.*

21 Laura Parisi and Rachel Klein, *Covering Pregnant Women: CHIPRA Offers a New Option*, accessed May 31, 2016, http://familiesusa.org/sites/default/files/product_documents/Covering-Pregnant-Women.pdf.

22 National Immigration Law Center, *Medical Assistance Programs for Immigrants in Various States*, accessed May 31, 2016, <https://www.nilc.org/wp-content/uploads/2015/11/med-services-for-imms-in-states.pdf>.

23 National Latina Institute For Reproductive Health, *Deferred Action for Childhood Arrivals (DACA) and Reproductive Justice*, accessed May 31, 2016, <http://latinainstitute.org/sites/default/files/Deferred-Action-for-Childhood-Arrivals-and-Reproductive-Justice-NLIRH-Fact-Sheet.pdf>.

24 National Immigration Law Center, *Medical Assistance Programs for Immigrants in Various States*, accessed May 31, 2016, <https://www.nilc.org/wp-content/uploads/2015/11/med-services-for-imms-in-states.pdf>.

25 Mayor's Task Force on Immigrant Health Care Access, *Improving Immigrant Access to Health Care in New York City*, accessed May 31, 2016, <http://www1.nyc.gov/assets/home/downloads/pdf/reports/2015/immigrant-health-task-force-report.pdf>.

26 Julia Gelatt and Heather Koball, *Immigrant Access to Health and Human Services: Final Report*, accessed May 31, 2016, http://www.urban.org/research/publication/immigrantaccess-health-and-human-services-final-report/view/full_report.

27 Cindy Rodriguez and Jaqueline Hurtado, "States work around Obamacare to help undocumented immigrants," CNN, April 9, 2014, <http://www.cnn.com/2014/04/09/us/obamacare-undocumented-immigrants/>.

28 National Immigration Law Center, *Medical Assistance Programs for Immigrants in Various States*, accessed May 31, 2016, <https://www.nilc.org/wp-content/uploads/2015/11/med-services-for-imms-in-states.pdf>.

that PRUCOLs are granted equal access to public health insurance.²⁹ Some of these programs and others with varying models are outlined in the following table:

State Programs

DC Health Care Alliance	The DC Healthcare Alliance provides medical assistance to District of Columbia residents who have incomes at or below 200% of the FPL, are ineligible for Medicaid or Medicare, and are without health insurance. The program covers preventive, primary, and prenatal care, as well as prescription drugs, dental services up to \$1000, and lab services. Enrollees are assigned to a managed care health plan and do not have cost sharing or fees for health services. ³⁰
My Health LA	This program is run by the Los Angeles County Department of Health Services. To be eligible, one must: have incomes at or below 138% of the FPL, live in LA County, age six or older, is ineligible for Covered California and Medi-Cal, and doesn't have other health insurance. Enrollees are not required to show proof of legal residency. Covered services include primary care at community-based health centers, where patients are assigned medical homes. The program also covers emergency, urgent care, and specialty services at LA County Department of Health Services-run facilities. ³¹
Healthy San Francisco	San Francisco Department of Public Health runs this program in which participants enroll with a medical home. It covers emergency and urgent care, ambulance services, hospital care, primary and preventive care, approved prescription drugs, specialty care, mental health services, alcohol and drug treatment, lab tests, family planning, and STD testing. Participants are responsible for patient fees based on a sliding scale and sometimes for point of service fees. To be eligible for the program, one must be a San Francisco resident, have a combined family income at or below 500% of the FPL, be uninsured for at least 90 days, be ineligible for Medi-Cal, Medicare, or other public insurance programs, and be age 18 or over. ³²
Massachusetts Health Safety Net Fund	This program was first created as part of Massachusetts' health care reform and helps pay for health services for specific low-income, uninsured, and underinsured individuals. Services can be used at hospitals and community health services. Citizenship is not required to be eligible but Massachusetts residency is. Co-payments are required for prescriptions for recipients who are over the age of 21. At community health centers, sliding fee scales are required for outpatient services. There are three coverage categories: primary for uninsured people with family incomes up to 200% FPL, secondary for underinsured individuals with family incomes up to 200% FPL, and partial for patients with family incomes between 201 and 400 % FPL, and patients with partial coverage are responsible for a deductible. In addition to the services identified for low income patients, other enrollees can have medical hardship status in the program, meaning their medical expenses exceed a specific percentage of their family income. For these individuals the Health Safety Net will pay for a percentage of services based on a sliding scale. ³³
New York City Direct Access	In 2015, New York City Mayor Bill de Blasio announced the creation of the Direct Access initiative, which had been recommended by the Mayor's Task Force on Immigrant Health Care Access. The program will launch as a pilot in 2016, coordinating access to care for uninsured immigrants in the city, and providing access to primary and preventive care through medical homes. Criteria exist to ensure cultural competency in these medical homes, and point of service fees will be based on a sliding fee schedule and must be consistent across all providers in the program's network. ³⁴
ROC-MD	ROC-MD is a health care cooperative run by the Restaurant Opportunities Center of Los Angeles. Members are uninsured restaurant workers who are members of Restaurant Opportunities Center of Los Angeles. Participants are eligible for primary and preventive care, law work, diagnostic exams, prescriptions, and some dental and vision care, provided at St. John's Well Child and Family Center, an FQHC system in Los Angeles. Restaurants also have the option to pay a monthly fee to cover all of their eligible employees. ³⁵

29 Mayor's Task Force on Immigrant Health Care Access, *Improving Immigrant Access to Health Care in New York City*, accessed May 31, 2016, <http://www1.nyc.gov/assets/home/downloads/pdf/reports/2015/immigrant-health-task-force-report.pdf>.

30 "Health Care Alliance," Department of Health Care Finance, accessed May 31, 2016, <http://dhcf.dc.gov/service/health-care-alliance>.

31 "My Health LA," Health Services Los Angeles County, accessed May 31, 2016, <https://dhs.lacounty.gov/wps/portal/dhs/coverageoptions/myhealthla>.

32 "Healthy San Francisco," San Francisco Department of Public Health, accessed May 31, 2016, <http://healthysanfrancisco.org/>.

33 "Resources for Health Care in Massachusetts," Health and Human Services, accessed May 31, 2016, <http://www.mass.gov/eohhs/consumer/insurance/more-programs/health-safety-net/for-patients.html>;

"Hospital Accountability Project: Massachusetts," Community Catalyst, accessed May 31, 2016, <http://www.communitycatalyst.org/initiatives-and-issues/initiatives/hospital-accountability-project/free-care/states/massachusetts>.

34 Mayor's Task Force on Immigrant Health Care Access, *Improving Immigrant Access to Health Care in New York City*, accessed May 31, 2016, <http://www1.nyc.gov/assets/home/downloads/pdf/reports/2015/immigrant-health-task-force-report.pdf>.

California's Health For All Act

While the ACA excludes undocumented immigrants from participating, states can use their own funds to establish mirror exchanges for excluded immigrant groups and provide income-based subsidies. In 2014, California state Senator Ricardo Lara introduced the Health For All Act, which would extend Medi-Cal benefits to undocumented immigrants living in California who meet the income eligibility requirements. In addition, it would require the state to apply for a 1332 waiver, an opportunity created under the ACA that allows states to modify implementation of the law, if approved by the federal government. If approved, the state could create a marketplace available to undocumented immigrants and DACA recipients previously excluded from purchasing plans on the health insurance marketplace.³⁶ In 2015 the state legislature passed a modified Health for All Kids bill, expanding full-scope Medi-Cal to all children regardless of immigration status.³⁷ The legislation directing the state to submit a 1332 waiver application to create a mirror insurance marketplace passed the legislature in June 2016 and was approved by Governor Jerry Brown

shortly thereafter.³⁸ While the proposal has received the stated support of Covered California and a broad advocacy coalition in the state; a 1332 waiver would need to be approved by the federal government.

Conclusion and Recommendations

While states, cities, and local communities have implemented proactive policies and programs designed to meet the health care needs of the uninsured immigrant population, these solutions are merely temporary, for coverage and health care access are not synonymous and federal statutory and regulatory reforms are greatly needed. NFPRHA believes that lawmakers should eliminate the five-year bar on Medicaid and CHIP enrollment, allow all immigrants regardless of status the opportunity to purchase marketplace plans with tax credits, if eligible, and roll back the prohibitive proof of citizenship requirements. Coverage does not equal care, and other challenges that prevent coverage from meeting its full potential must also be addressed, such as reimbursement rates and a provider shortage across the health system. In

addition, advocates must focus more attention on other systemic factors that deny immigrants access to health care and render them vulnerable to poor health outcomes. Efforts are ongoing and must continue to address cultural competency, develop a workforce of greater demographic and geographic diversity, better serving patients with limited English proficiency, among other related challenges. With no statutory or regulatory changes made nationally, states and safety-net providers are called upon to meet the growing health needs and fill in the gaps. Title X-funded health centers serve as an essential point of access to care for all patients, regardless of immigration status and have long been a source of safe, high-quality, trusted family planning and sexual healthcare. For immigrants who are ineligible for public insurance, Title X-funded care is often the only health care provider available. Furthermore, state and federal officials must dedicate more resources to mitigate the factors degrading immigrants' access to health care and coverage, and in particular better support safety-net providers who are often on the front lines of delivering care to immigrant communities.

- 35 "ROC M.D.," ROCUNITED, accessed May 31, 2016, <http://rocunited.org/our-work/membership-leadership-development/roc-md/>.; Anna Gorman, "L.A. program offers healthcare for illegal restaurant workers," Los Angeles Times, May 3, 2012, <http://articles.latimes.com/2012/may/03/local/la-me-health-restaurant-workers-20120503>.
- 36 California Immigrant Policy Center and Health Access, *SB 4 (Lara): Allowing All to Buy into Covered California*, accessed June 3, 2016, http://www.caimmigrant.org/wp-content/uploads/2015/08/sb4_cipc_healthaccess_factsheet_Aug20_final.pdf.
- 37 Ricardo Lara, "Governor Signs Lara's Health for All Kids Act," news release, October 9, 2016, <http://sd33.senate.ca.gov/news/2015-10-09-governor-signs-lara%E2%80%99s-health-all-kids-act>.
- 38 Jeremy B. White, "Gov. Jerry Brown agrees to seek health insurance for undocumented immigrants," *The Sacramento Bee*, June 10, 2016, <http://www.sacbee.com/news/politics-government/capitol-alert/article83066117.html>.

About NFPRHA

Founded in 1971 and located in Washington, DC, the National Family Planning & Reproductive Health Association (NFPRHA) is a 501(c)3 non-profit membership organization representing the broad spectrum of family planning administrators and providers who serve the nation's low-income, under-insured, and uninsured women and men.

As the only national membership organization in the United States dedicated to increasing family planning access, NFPRHA is committed to advocacy, education, and training for its members. NFPRHA works to help ensure access to voluntary, comprehensive, and culturally sensitive sexual and reproductive health care services and supplies, and to support reproductive freedom for all.

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