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THE INVISIBLE UNINSURED: NON-CITIZENS AND ACCESS TO HEALTH CARE COVERAGE UNDER THE AFFORDABLE CARE ACT

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People immigrate to the United States in hopes of making a better life for themselves, their family and their children. They may seek employment, health care and freedom from poverty or persecution in their home country. The term "immigrant" or "non-citizen" covers a wide range of people who come to and stay in the United States for different reasons. Non-citizen is the most encompassing term so we have used it in this article to represent many categories of people who visit or reside in the United States. Immigrants and

visitors enter the United States with different types of legal documentation and may change their status during their stay in the United States. Legal status and immigration documentation largely determines if a person is eligible to receive government benefits such as public health insurance.[2]

Some immigrants enter the United States with the intention of becoming legal permanent residents and, eventually, United States citizens; however, these opportunities are limited. Some foreign nationals enter the United States for a designated time period as employees or students and do not intend on immigrating or becoming permanent residents. Visitors often come into the United States on a tourist visa or other temporary visa.

Most commonly, visitors who stay beyond the length of their visa potentially become "undocumented", or without legal documentation to remain in the country. If they become sick or disabled and unable to work or care for themselves or their family here in the United States, they have very limited access to public health care coverage. Many low-income jobs do not provide health insurance to their employees and private health insurance is often prohibitively expensive. In addition, immigrants and other non-citizens are rarely eligible for public medical coverage such as Medicaid and Medicare.[3] Unfortunately, the Patient Protection and Affordable Care Act ("ACA") may not significantly improve the health insurance status of non-citizen populations.[4]

Medicaid is the largest insurer in the nation of people under age 65.[5] The federal Social Security Act and conforming regulations govern eligibility and coverage under Medicaid with some variation among the states.[6] Eligibility for and access to medical coverage under Medicaid and other public programs generally depend upon four major factors: categorical eligibility, citizenship/immigration status, income and assets. Categorical eligibility for Medicaid includes adults over age 65, pregnant women, children under age 19, parents of children under age 19 and people with disabilities. In 2014, this categorical eligibility will also expand to non-disabled adults without minor children.[7]

However, current citizenship and immigration requirements will continue to apply to all categories of coverage under Medicaid with the exception of pregnant women and children under age 19 who may have more liberal requirements applied at state option.[8] As the ACA largely followed the regulatory scheme of Medicaid, it did not expand or broadly liberalize access to coverage under Medicaid. The only other significant new avenue for health care cover-

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age authorized in the Affordable Care Act are the opportunity for some lawfully present non-citizens, including legal permanent residents, to purchase health insurance through state health benefits exchanges or cooperatives.

Availability of Public and Private Health Care Coverage for Non-Citizen Populations Historically, non-citizens have faced challenges obtaining health care coverage due to a myriad of issues including a failure to meet the eligibility requirements for Medicaid, limited availability of coverage through employment and low income.[9] While non-citizens are approximately 7 percent of the total population, they make up 21 percent of the uninsured population. They are also more likely to have characteristics associated with being uninsured, including youth, low income, Hispanic ethnicity and employed by small employers who are less likely to offer health insurance.[10] Therefore, due to the lack of access to private insurance and lack of eligibility for public insurance, non-citizens are disproportionately more likely to have no health care coverage available to them.

As a result of a political backlash against non-citizens combined with a similar backlash against welfare recipients, eligibility for Medicaid and other public programs was significantly curtailed in 1996 with the passage of the Personal Responsibility and Work Opportunity Reconciliation Act. While Medicaid remains generally available to certain special populations (e.g., legal permanent residents after they have been lawfully present in the country for 5 years, pregnant women, refugees, asylees and victims of domestic violence, torture and trafficking), undocumented and temporary immigrants remain ineligible for Medicaid regardless of their length of residency in the country except for coverage of limited emergency conditions.[11] Restriction on public health care coverage for undocumented non-citizens continues to be debated as a major political issue often wrapped up in debates over immigration policy.

Documentation of citizenship and identity has provided another hurdle to coverage for non-citizens as well as for citizens. The citizenship documentation requirement, first imposed in the Deficit Reduction Act of 2005,[12] requires a new and arduous level of identification and documentation to prove eligibility for Medicaid. A class of Medicaid recipients, many of them elderly, disabled and unable to adequately prove their citizenship due to a host of barriers including lack of original birth certificates, lack of passports, missing identity information and sealed adoption files, challenged the legality of these requirements that required Medicaid applicants and recipients who claim to be

United States citizens to prove their citizenship in some instances after decades of receiving Medicaid.

Although some populations, notably foster children, SSI recipients and Medicare beneficiaries, were eventually exempted from the requirements after the dismissal of *Bell v. Leavitt*, most applicants for Medicaid must still meet these requirements.[13] These restrictions are often difficult for citizens to meet (e.g. presenting a United States Passport, original birth certificate and certified documentation), and, while they do not directly affect non-citizens, the chilling effect of requiring a high level of documentation from applicants for health care coverage can discourage any applicant from seeking coverage. Similarly, non-citizens may be afraid to seek health care coverage for their citizen children or for themselves for fear of being reported to immigration authorities, even though it is well-established that applying for health benefits can have no impact on immigration status or deportation risk.[14]

Emergency medical coverage under Medicaid remains one of the only exceptions to the limitations posed for non-citizens in Medicaid and the ACA.[15] Emergency Medicaid is available to those immigrants who are in need of emergency services, assuming they meet the other eligibility requirements. Some states also have state-funded only programs to fill the coverage gaps in Medicaid and CHIP for low-income, lawfully residing non-citizens who would otherwise be ineligible for Medicaid.[16] For example, several states provide coverage to children regardless of their immigration status, including Massachusetts, Illinois, New York and Washington states, as well as the District of Columbia.[17] The state option in the ACA to provide Medicaid and SCHIP to children and pregnant women who are lawfully present but have not yet met the 5-year bar may expand the number of states who cover non-citizen children and will surely be a focus for collaborative advocacy.

Advocacy efforts to expand coverage to non-citizens have focused on building collaborations between providers, consumers, and community based organizations to organize support for health care access. Hospitals and Federally Qualified Health Centers that serve ineligible undocumented non-citizens have a joint interest with advocates and consumers in expanding coverage to these populations as a potential funding source for their care.

However, advocacy efforts are typically more successful for non-citizens who have legal status than for those who have no legal status. For example, a class of

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non-citizens with legal status successfully enforced their rights to state insurance focusing on the inequality between citizens and non-citizens in the provision of health care. The Massachusetts State Supreme Court held that the restrictions in access to state health insurance imposed violated the equal protection rights of legal immigrants.[18] Still, the problem of coverage for undocumented or "illegal" immigrants remains largely unaddressed.

Collaboration Leads to Policy Reform: *All Kids* and the Expansion of Health Care Coverage to Non-Citizen Children in Illinois

Public opinion and political discourse has narrowed the support for health care coverage for non-citizens over the past decade, especially those persons who do not have legal documentation for being present in the United States. Federal Medicaid law has restricted eligibility and narrowed the emergency coverage for non-citizens exceptions, resulting in less funding for health care for undocumented immigrants. At the same time, collaborations between social activists, advocates and providers have convinced some states to expand coverage through state-only funds seeing the value in maintaining population health (e.g. vaccinating children of all immigration status to avoid communicable diseases) and covering preventative health care to avoid more expensive emergency and urgent care costs in the future. There have been multiple political amnesty and health care coverage proposals through federal and state legislation primarily focusing on children such as the DREAM Act but they have been largely unsuccessful.[19] The focus among collaborative partners in Illinois, therefore, has been to protect coverage for non-citizen children at a minimum.

Illinois set an early example for the nation in expansion to uninsured children regardless of immigration status by creating All Kids in 2005. This was in part a response to the settlement in *Memisovski v. Maram*, a class action in which Illinois was found to be in non-compliance with federal law in the provision of equal access to providers and Early and Periodic Screening Diagnosis and Treatment for children on Medicaid. A collaboration of providers, hospitals, policymakers, advocates for children and consumers came together in unprecedented support for health care coverage for all children and the law implementing coverage passed easily in the state legislature. All Kids, although under frequent political attack, continues to cover children under 300% of the Federal Poverty Level ("FPL") regardless of immigration status. This coverage has

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resulted in one of the highest insured rates of children in the nation and set an example for health care reform and the reauthorization of SCHIP.[20]

It is unknown whether Illinois will continue All Kids coverage for undocumented children beyond the implementation of health care reform in 2014. The coverage of children who do not meet federal Medicaid immigration requirements must be financed with state-only funds. These funds are always in jeopardy during a difficult budget climate. In addition, audits of the Illinois All Kids program have provided fodder for its critics finding that Illinois categorizes some children as undocumented when they actually qualify for federal Medicaid. In order to improve political support for the program, Illinois needs to improve documentation of citizenship and immigration status to maximize federal funding. Such an improvement could bring in more federal financial participation and strengthen political support for the coverage.

The Affordable Care Act: What It Will Mean for Non-Citizens

Under the Affordable Care Act, non-citizens are divided into two groups: "Qualified" and "Non-Qualified", generally referring to whether they are qualified for health benefits under the ACA.[21] Qualified non-citizens are generally legal permanent residents who have been lawfully present in the United States for at least 5 years, as well as certain humanitarian immigrants, such as refugees, persons granted asylum or withholding of deportation/removal, conditional entrants, persons granted parole for a period of at least one year by the Department of Homeland Security, Cuban and Haitian entrants, certain abused immigrants and their families, and certain victims of human trafficking.[22] All other non-citizens, including undocumented non-citizens are considered "Non-Qualified."[23] As non-qualified, they cannot enroll in major public benefits programs, including Medicaid, The State Children's Health Insurance Program ("SCHIP"), or Medicare.[24]

Even when qualified, most non-citizens must still wait for the 5-year period before they may apply for Medicaid, with the notable exception of lawfully residing children and pregnant women who can be covered by state option without a 5-year waiting period.[25]

The ACA will also significantly expand Medicaid by requiring states to cover nearly all people under the age of 65 with household incomes at or below 133

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percent of the FPL beginning in January 2014.[26] This expansion will mean that many low-income people will now be eligible for Medicaid who have formerly been ineligible for Medicaid due to their failure to meet categorical eligibility (i.e. they have not fit in a prior category of coverage such as pregnant women, children, parents, disabled or elderly). Medicaid expansion for each participating state will be covered by the Federal Government at 100 percent of the state's costs of coverage in 2014, with a gradual decrease in funding to 90 percent over time through 2020.[27] Thus, the Medicaid expansion could make a considerable difference in coverage among childless adults who meet the income requirements for Medicaid including qualified non-citizens. However, the Medicaid expansion will not expand coverage to non-citizens who not qualified – generally those with no legal documentation or who are lawfully present but have not yet met the 5-year bar.

One of the most controversial elements of the ACA is the individual mandate, which requires citizens and some non-citizens who are deemed financially able (and not eligible for Medicaid) to purchase insurance, either through an employer or by purchasing an individual plan.[28] Those who fail to purchase insurance will be subject to financial penalties.[29] Legal permanent residents are generally subject to the individual mandate.[30] In addition, some non-citizens will be subjected to the mandate.[31] Non-citizens, however, are exempt from the individual mandate if they are not expected to be in the United States for the whole period of enrollment for an insurance plan.[32] The shortest period of enrollment available will not be known until the state-run health benefits exchanges are operational. Currently, no one will be fined for not having coverage for less than 3 months (limited to one 3-month period in a year). Therefore, non-citizens residing in the United States for a period shorter than 3 months within one year will not be fined.[33] Undocumented non-citizens will not be subject to the mandate, as they are ineligible for coverage.[34]

The American Health Benefit Exchanges

The ACA calls for the establishment of a "health benefits exchange" in every state.[35] The exchange is intended to provide a user-friendly marketplace to allow consumers to purchase an insurance plan that best suits their needs.[36] The exchange has the potential to create a regulated, competitive environment that ideally will decrease the cost of health insurance.[37] States will have the option to implement increased consumer protections into the structure of the

exchange.[38] These factors combined are predicted to make insurance purchased through the exchange more affordable to Americans. Furthermore, those persons who have incomes between 133-400 percent of the FPL will be eligible for tax credits, which are intended to make purchasing insurance easier financially.[39]

Lawfully present non-citizens will be allowed to purchase insurance through the exchange and are eligible for certain tax credits.[40] Undocumented non-citizens, however, still will not be allowed to purchase insurance through these exchanges and are also ineligible for any tax credits, regardless of whatever other qualifications they may meet.[41] Certain lawfully present non-citizens who are in the United States for a temporary period will also be allowed to purchase insurance through the exchange if they are in the United States for a period of time long enough to subject them to the individual mandate or if they will be in the country for the full enrollment period of the plan.[42]

CO-OP: Consumer Operated and Oriented Plan

The Affordable Care Act afforded an opportunity to qualified nonprofits to provide health insurance to the individual and small group market.[43] These co-ops are designed specifically to provide an alternative to the state and federal administered health care exchanges and to be administered with a strong consumer focus.[44] Co-ops may receive federal loans but since they are not a state or federal entity, the requirements for eligibility to purchase insurance in the co-op including citizenship and immigration status is not governed by federal or state law. Thus, Co-ops may provide another new opportunity for non-citizens to purchase health insurance if they do not meet the eligibility requirements for Medicaid or to purchase health insurance in the health benefits exchange.

Conclusion

The Affordable Care Act did not significantly expand health care coverage for non-citizens, especially for those with no legal documentation.[45] The ACA liberalizes the requirements for legal resident children and pregnant women to qualify for Medicaid, but only at state option. It is hoped that more states will exercise this option and coverage will be expanded to these populations; how-

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ever, states are facing budget deficits that may prevent significant expansion in the near future. The ACA also allows lawfully present non-citizens to purchase health insurance through the health care exchanges with a subsidy; however, undocumented non-citizens will experience little or no change in their access to coverage.

These reforms will certainly expand coverage to certain non-citizens and improve financing of health care to non-citizens; however, providers such as safety net hospitals and federally qualified health centers will most likely continue to bear the burden of uncompensated care for the undocumented population. The ACA also invests significant funds into community health centers to bolster their ability to care for the uninsured in general, which may help to finance continuing care for undocumented populations.[46]

Collaborations of providers, advocates and consumers have been partially successful in the expansion of Medicaid coverage for non-citizen children and for lawfully present non-citizens. Traditional safety-net providers including Federally Qualified Health Centers, clinics, school health centers, and hospitals will remain the primary access points for immigrants without health insurance or Medicaid. These providers may be better able to handle the financial burden of caring for uninsured immigrants because of the cost-shifting through the move to more insured patients. However, as more non-immigrants are insured in 2014 through the Affordable Care Act, the patient distribution patterns may change, leaving some hospitals such as County hospitals and clinics with a greater percentage of the uninsured immigrant population. The "problem" of providing and paying for health care for non-citizens who are undocumented or otherwise ineligible for public coverage will remain a burden for those individuals and on our health care system.

NOTES

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2 Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA), P.L. 104–193 (Aug. 22, 1996), which placed new limitations on federal funding for health coverage of immigrant families; Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA), P.L. 111–3, Section 214, which permits states to cover certain children and preg-

nant women in both Medicaid and CHIP. See also Claudia Schlosberg, *Immigrant Access to Health Benefits,* The Access Project, National Health Law Program (1999-2000).

3 *Id.*

4 Patient Protection and Affordable Care Act, P.L. 111–148 (Mar. 23, 2010).

5 The Henry J. Kaiser Family Foundation, *Medicaid Enrollment: December 2010 Data Snapshot,* Kaiser Comm'n on Medicaid Facts (Dec. 2011), *available at* http://www.kff.org/medicaid/upload/8050-04.pdf; *see also,* Medicaid and Medicare Summaries 2011, Centers for Medicare and Medicaid Services, http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/MedicareProgramRatesStats/SummaryMedicareMedicaid.html.

6 Social Security Act, 42 U.S.C.1396 et seq.; 42 C.F.R. § 430 et seq. Every state plan consists of a mix of required and optional categories of health services. *See also* 42 U.S.C. § 1396d(a).

7 Patient Protection and Affordable Care Act, P.L. 111–148 (Mar. 23, 2010).

8 Children's Health Insurance Program Reauthorization Act, P.L. 111–3 (Feb. 4, 2009); see also Centers for Medicaid, CHIP and Survey Certification, Letter to State Health Officials, *Medicaid and CHIP Coverage of "Lawfully Residing" Children and Pregnant Women,* http://downloads.cms.gov/cmsgov/archived-downloads/SMDL/downloads/SHO10006.pdf.

9 Leighton Ku, *Why Immigrants Lack Adequate Access to Health Care and Health Insurance,* Migration Policy Institute, Migration Information Source, Center on Budget Policies and Priorities (Sept. 2006), *available at* http://www.migrationinformation.org/usfocus/display.cfm?ID=417. *See also* Ruth Ellen Wasem, *Noncitizen Eligibility and Verification Issues in Health Care Reform Legislation,* Congressional Research Service, (Apr. 20, 2010).

10 Department of Health and Human Services; Overview of the Uninsured in the United States, http://aspe.hhs.gov/health/reports/05/uninsured-cps/index.htm#citizenship.

11 Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA), P.L. 104-193, (Aug. 22, 1996).

12 Deficit Reduction Act of 2005, P.L. 109–171 (2006) Section 6036.

13 Bell v. Leavitt, *2007* U.S. Dist. LEXIS 11675 (*N.D. Ill.* Feb. 16, 2006), a suit which challenged the legality of provisions in the 2005 Deficit Reduction Act and HHS implementing regulations that required Medicaid applicants and recipients who claim to be United States citizens to prove their citizenship with passports, birth certificates and other special documents. Immediately after the case was filed, defendant Secretary of HHS exempted SSI and Medicare beneficiaries from the documentation requirement, a change that exempted approximately eight million disabled and elderly people. Subsequently, Congress corrected defendants' misinterpretation of the 2005 Deficit Reduction Act and expressed its intent that 500,000 foster children and children receiving adoption assistance be exempt from the citizenship documentation requirement. Concluding that the potential for further progress in a nationwide class action is limited, plaintiffs decided to dismiss the case voluntarily and to clear the way for activity on the state level, including possible litigation. Sargent Shriver National Center on Poverty Law, *Parties Voluntarily Dismiss Action Challenging Citizen Documentation Requirements for Medicaid,* No. 06 C 3520 (N.D. Ill., May 7, 2007), available at http://www.povertylaw.org/poverty-law-library/case/56000/56034. *See also* U.S. Government Accountability Office, *States Reported That Citizenship Documentation Requirement Resulted in Enrollment Declines for Eligible Citizens and Posed Administrative Burdens,* GAO-07-889 (June 2007), *available at* http://www.gao.gov/new.items/d07889.pdf.

14 Tova Andrea Wang, *Welfare Reform and Immigrants,* Century Foundation (2002); *see also Beyond Stigma: What Barriers Actually Affect the Decisions of Low-Income Families to Enroll in Medicaid,* Sara Rosenbaum, J.D. et al., Issue Brief, July 2000.

15 42 U.S.C. §1396 (v)(1)–(3); 42 C.F.R. §440.255

16 Office of the Assistant Secretary for Planning and Evaluation, *Overview of Immigrants' Eligibility for SNAP, TANF, Medicaid, and CHIP*, ASPE Issue Brief (Mar. 2012), *available at* http://aspe.hhs.gov/hsp/11/ImmigrantAccess/ib.pdf.

17 *Id.*

18 *Finch v. Commonwealth Health Insurance Connector Authority*, 461 Mass. 232 (2011).

19 Development, Relief, and Education for Alien Minors Act, S-1291 (107th), (June 20, 2002).

20 *See specifically* Kaiser Commission on Medicaid, *As Tough Times Wane, States Act to Improve Medicaid Coverage and Quality: Results from a 50-State Medicaid Budget Survey for State Fiscal Years 2007-2008*, (Oct. 2007), *available at* http://www.kff.org/medicaid/upload/7699.pdf; *see similarly* Teresa A. Coughlin & Mindy Cohen, Kaiser Commission on Medicaid, *A Race to the Top: Illinois All Kids Initiative* (Aug. 2007), *available at* http://www.kff.org/uninsured/upload/7677.pdf.

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22 *Id.*

23 *Id.*

24 *Id.*

25 *Id.*

26 *Id.*

27 *Id.*

28 *Id*

29 *Id.*

30 *Id.*

31 *Id.*

32 *Id.*

33 *Id.*

34 *Id.*

35 *Id.*

36 *Id.*

37 *Id. See also* The Henry J. Kaiser Family Foundation, *What's An Exchange?* Kaiser Health News (July 10, 2009), *available at* www.kaiserhealthnews.org/stories/2009/july/10/exchangesqa.aspx.

38 *Id. See also* Sarabeth Zemel, Abigail Arons, Christina Miller, et al., *Building a Consumer-Oriented Exchange: Key Issues*, National Academy for State Health Policy (Feb. 2002), *available at* www.nashp.org/sites/defaul/files/Building_a_Consumer_Oriented_Exchange_final.pdf.

39 *Id.*

40 *Id.*

41 *Id.*

42 *Id.*

43 Patient Protection and Affordable Care Act, P.L. 111-148 (Mar. 23, 2010) (Section 1322 of the PPACA implements the co-op system and defines "a qualified nonprofit health insurance issuer."). *See also* 45 CFR Part 156 Final Rule on Establishment of Consumer Operated and Oriented Plan (Co-op) Program (Dec. 13, 2011).

44 Hinda Chaikind, Bernadette Fernandez, Mark Newsom, & Chris L. Peterson, Private Insurance Provisions in the PPACA, Congressional Research Service, R40942 (May 4, 2010), *available at* www.opencrs.com.

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