



California's Implementation of the Affordable Care Act

Implications for Immigrants in the State

Julia Gelatt, Heather Koball, and Juan Manuel Pedroza

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

Introduction

This brief examines how the implementation of the Patient Protection and Affordable Care Act of 2010 (ACA) in California might affect immigrants' access to health care in the state.¹ We first describe the implementation of the ACA in California generally, and then turn to implications for immigrants (particularly low-income immigrants) in the state. We highlight promising state-specific policies that may increase the share of immigrants with some form of health insurance coverage. We also describe ongoing challenges in connecting immigrants to insurance for which they are eligible. We conclude by highlighting areas where California's experience could provide useful approaches for other states to consider as they implement the ACA and work to improve health insurance coverage of all residents in their state.

Background

Across the United States, approximately 15 percent of the population had no form of health insurance as of 2012 (DeNavas-Walt, Proctor, and Smith 2012). Immigrants make up a disproportionate share of

the uninsured population: they were 20 percent of the uninsured population in 2012, but only 7 percent of the US population overall (DeNavas-Walt, Proctor, and Smith 2012).² As states across the country begin implementing the ACA, they face many policy choices within the provisions of the law. The choices states make may affect whether and how immigrants are able to find new sources for health insurance coverage. In this brief, we examine one state—California—as a case study to help better understand how state decisions may affect immigrants' access to health insurance under the ACA.

Nationwide, immigrants are less likely than citizens to have health insurance. For example, among nonelderly immigrants, about 51 percent of adults had no health insurance in 2009, compared with 17 percent of US-born citizen adults (Kenney and Huntress 2012). This gap in insurance coverage is driven by lower rates of both employer-sponsored insurance coverage and public coverage for immigrants. Lower rates of public health insurance coverage stem, in part, from Medicaid and Children's Health Insurance Program (CHIP) eligibility criteria that generally exclude recent legal permanent residents (LPRs) for their first five years in the country and exclude unauthorized immigrants for as long as they are unauthorized. However, there is some state flexibility regarding providing public health insurance to lawfully present immigrants, particularly pregnant women and children, within their first five years of legal residence. And states are free to use state funding to provide public insurance to immigrants regardless of legal status, though few do so and such insurance is generally provided only to children. The share of the uninsured population who are immigrants is expected to rise as ACA implementation progresses. While many US citizens and a substantial share of LPRs gain new access to Medicaid under the ACA, most new LPRs and unauthorized immigrants do not.

California has more immigrants than any other state, so its policies affect the lives of many immigrants. About one-quarter of the foreign-born population in the United States, or 10 million foreign-born people, live in California. While 13 percent of the US population is foreign born, in California this share is 27 percent (Migration Policy Institute 2013). It is also estimated that more unauthorized immigrants live in California than any other state: about 2.6 million, or just under a quarter of the estimated 11.2 million national total (Passel and Cohn 2011). Half of all children (49.6 percent) in California have at least one foreign-born parent (Migration Policy Institute 2013).

This brief is based on a site visit to California in February 2013 and publicly available information. The site visit included discussions with state and local government agencies, nonprofit service providers, advocacy organizations, professional organizations for health care workers, public-private service providers, and a private company contracting with the state. No immigrant families were contacted during the site visit. This brief provides information about California's policies and practices before the ACA, plans for ACA implementation, and knowledge about the likely impact of state and local policies on immigrants seeking health insurance.

Below, we briefly outline changes in federal policy under the ACA and the policies California is implementing within this context. We then highlight the impacts of these policies on immigrants in California. Finally, we highlight California's promising practices, as well as ongoing challenges in connecting the state's immigrant population with health insurance options.

California's Policies under the Affordable Care Act

A previous [brief](#) in this series, “The Affordable Care Act: Coverage Implications and Issues for Immigrant Families,” outlines the implications of federal ACA provisions for immigrant families (Kenney and Huntress 2012). This section briefly reviews federal policy changes under the ACA and then identifies the decisions that California has made within the federal framework.

Medicaid. The ACA gives states the option of expanding federally funded Medicaid to individuals with household incomes at or below 133 percent of the federal poverty level (FPL), with the federal government picking up most of the cost of this expansion.³ California's legislature voted in June 2013 to undertake this expansion. Prior to the ACA, many states, including California, did not offer Medicaid to nondisabled, childless adults, and income eligibility guidelines for adults generally fell far below 133 percent of FPL. Many counties in California began preparing for the anticipated expansion by creating Low Income Health Plans (LIHPs). The California LIHPs, which launched in July 2011, were federally funded demonstration projects that extended public insurance to adults who were not previously eligible. Those covered under the LIHPs included citizens and qualified⁴ immigrants with incomes meeting county eligibility criteria, most often below 133 percent of FPL, whether parents or childless adults. The LIHPs provided coverage through the end of 2013, when those covered were enrolled in Medi-Cal (the state's Medicaid program) or the state health insurance marketplace,⁵ called Covered California (California Department of Health Care Services 2011). Some counties, such as Los Angeles, opened their LIHPs to nonqualified immigrants using local funding only. Los Angeles County will continue its LIHP, Healthy Way L.A., in 2014 and beyond using local funds, to continue providing insurance to those with low incomes who are not eligible for Medi-Cal or Covered California, such as nonqualified immigrants (Insure the Uninsured Project 2013).

Health insurance marketplaces. The ACA creates state health insurance marketplaces where lawfully present immigrants who do not have sufficient employer-provided health insurance can purchase private insurance. Those with family incomes up to 400 percent of FPL are eligible for tax credits that limit the premium paid for health insurance to a percentage of income—ranging from 2 percent for those with incomes at or below 133 of FPL to 9.5 percent for those at 400 percent of FPL. Those with incomes below 250 percent of FPL are also eligible for cost-sharing subsidies to help pay deductibles and copayments. Lawfully present⁶ immigrants may participate in state insurance marketplaces and receive tax credits and subsidies for which they are income-eligible even during their first five years of legal status. California was the first state in the country to set up a state health insurance marketplace. The marketplace, Covered California, opened for enrollment in October 2013, and insurance coverage started in January 2014.

Funding for primary care. The ACA also offers some changes in federal funding for health insurance and health care providers that could affect safety net care for individuals who remain uninsured under the ACA, such as unauthorized immigrants. The ACA mandates increased funding for community health centers and other federally qualified health centers (FQHCs) and FQHC look-alikes, which are a key source of care for the uninsured. The ACA also temporarily increases federal payment rates for primary

care provided through Medicaid for 2013 and 2014, increasing revenues to local providers. Additionally, the ACA provides funding streams intended to increase the supply of primary care providers (Hill 2012). The inflow of new funding streams and an increase in the share of patients with insurance could free up additional funding to provide primary care for remaining uninsured individuals, such as unauthorized immigrants. At the same time, as the proportion of patients with insurance rises, the ACA will gradually lower funding for disproportionate share hospital payments to hospitals that serve large numbers of low-income, uninsured patients.

Outreach. The ACA requires states to set up systems of Navigators—individuals trained to provide outreach and assist state residents with enrollment in state health insurance marketplaces “in a manner that is culturally and linguistically appropriate to the needs of the population being served.”⁷ These service providers could increase coverage among eligible immigrant populations who may otherwise face information or language barriers in applying. The Department of Health and Human Services will provide \$150 million in funding for community health centers across the country to provide patients with assistance enrolling in new health insurance options, and \$67 million in grants to fund Navigators (Hill, Courtot, and Wilkinson 2013).⁸

Changes in public insurance for children. Leading up to implementation of the ACA, California changed how it administers the provision of health insurance for children in low-income families covered under the Children’s Health Insurance Program. CHIP covers insurance for children in working poor families with incomes above the eligibility limit for Medi-Cal. Until 2013, California ran a separately administered CHIP program called Healthy Families that covered children with family incomes up to 250 percent of FPL. In 2013, most children who had insurance under Healthy Families were transitioned onto insurance plans paid with CHIP funds but administered by Medi-Cal.

Bridge Plan for lower-income families. California’s health benefits exchange board approved a proposal, in 2013, for a Bridge Plan to help low-income families maintain continuous health insurance coverage as their incomes fluctuate over time.⁹ The ACA gave states the option of creating a special insurance plan—termed the “Basic Health Plan”—for families with incomes on the border of Medi-Cal eligibility. Low-income families often have incomes that vary over time, placing them within the income-eligibility range for Medicaid in some periods and above the range in other years. This churning in and out of Medicaid eligibility can lead to gaps in health insurance coverage and access to health care. By one estimate, half of adults with family incomes below 200 percent of FPL churn in or out of Medicaid eligibility in any given year nationwide (Sommers and Rosenbaum 2011).

Rather than create a separate health insurance program for those at the border of Medi-Cal eligibility, California proposed to maintain continuity of coverage and care for low-income families by allowing those at risk of churning to maintain coverage under the same managed care system that they access through Medi-Cal. Under the Bridge Plan, families would be able to maintain coverage if their incomes rose above 133 percent of FPL, as long as their incomes remained below 200 percent of FPL.

Parents of children with Medi-Cal would also be able to obtain coverage so that even parents ineligible for Medi-Cal could access care through the same providers as their children (the Medi-Cal

income eligibility cutoff for adults will be set at 133 percent of FPL, versus 250 percent of FPL for children). The state has also debated opening Bridge Plan eligibility to individuals with incomes below 200 percent of FPL who are not transitioning off Medi-Cal, but it has not pursued this option. Under the current proposal, Bridge Plan insurance would be purchased through the marketplace. Covered California would negotiate contracts with the managed care plans operating under Medi-Cal, in order to create plans with lower monthly premium costs than other plans purchased through the marketplace (Insure the Uninsured Project 2013).

Implications of California's ACA Policies for Immigrants and Their Families

California's policies under the ACA should substantially increase the availability of insurance for lower-income residents, including immigrants. In this section, we highlight the consequences of California's new health care policies for particular subgroups of the immigrant population.

Adult LPRs with at least five years in the country. California's new policies under the ACA expand coverage for many lawfully present immigrants in the state who have been LPRs for at least five years. Those with incomes below 133 percent of FPL are now eligible for Medi-Cal, even if they do not have dependent children. The Urban Institute estimates that 262,000 qualified immigrants in California could obtain Medi-Cal coverage under the ACA, making up 14 percent of the newly eligible population (Kenney et al. 2012). Low-income LPRs with incomes above 133 percent of FPL also benefit from the availability of subsidized insurance through the marketplace.

Adult LPRs with fewer than five years in the country. Recent LPRs in their first five years of residence benefit as well. Prior to the ACA's implementation, recently arrived LPR parents with family incomes below 100 percent of FPL could obtain Medi-Cal funded by the state. Under the ACA, new LPR adults who do not have children and have household income below 100 percent of FPL are able to obtain state-funded Medi-Cal, while new LPRs who are low income but not technically poor (family incomes between 100 and 400 percent of FPL) can purchase subsidized insurance through the state marketplace. For new LPRs with incomes between 100 and 133 percent of FPL, California uses a "premium assistance option" to help them purchase insurance through Covered California (Insure the Uninsured Project 2013).

Unauthorized immigrant adults. Unauthorized immigrant adults have no new insurance options under the ACA, but changes in funding streams might affect the availability of primary and emergency care for such immigrants, as explained above. As before the ACA's implementation, unauthorized immigrants in California, as in the rest of the country, are ineligible for Medicaid or Medi-Cal and are not allowed to purchase insurance through health insurance marketplaces, even if they use their own money to do so.¹⁰ This category of federally excluded individuals includes young adults who have benefited from Deferred Action for Childhood Arrivals (DACA), which provides a temporary reprieve from deportation and work authorization to unauthorized youth who arrived as children and who meet

certain eligibility criteria.¹¹ However, DACA recipients are eligible for state-funded, full-scope Medi-Cal under California law with the same income requirements as other California children and adults (Brindis et al. 2014).

California has various programs that provide health insurance, prescription medicine, and health care to select groups of high-need individuals, regardless of immigration status.¹² Some counties in California fund access to a broad system of care, regardless of immigration status. Among the most comprehensive is San Francisco County's Healthy San Francisco program, which provides low-income uninsured individuals who are ineligible for other insurance with access to primary and specialized care, hospital care, and prescriptions using state and local funds. This program is continuing as the ACA goes into full effect. Also, California is requiring that anyone selling insurance through the marketplace offer the same products at similar (unsubsidized) costs outside the marketplace, potentially opening new insurance coverage options even to those who cannot participate in the marketplace.

Children of immigrants. Children of immigrants have often had constrained access to health insurance—even though they themselves may be eligible—because of their parents' ineligibility for insurance, fears about accessing government benefits, and misunderstandings about different eligibility rules (Perreira et al. 2012). Most children of immigrants nationwide and in California are themselves US citizens or LPRs, so they are eligible for Medi-Cal if they live in low-income families (Passel and Cohn 2011). The ACA requires that states maintain current levels of Medicaid coverage for LPR children through September 2019, meaning that for at least that period, California children in their first five years of LPR status will remain eligible for Medi-Cal if their parents have incomes below 250 percent of FPL. The expansion of Medi-Cal and subsidized private insurance to many LPR parents could also increase the likelihood that parents know about and enroll their children in available insurance plans.

Under the ACA, unauthorized immigrants have new options for obtaining health insurance for their US-citizen children. Unauthorized immigrant parents can purchase insurance for their US-citizen children through state health care marketplaces, even though they are not allowed to purchase insurance for themselves. Income-eligible families can also access subsidies for children's insurance.

For the roughly 20 percent of children of unauthorized immigrants who are themselves unauthorized, the ACA does not open new options beyond those that already exist in some communities in California, though these children, like their parents, might be affected by changing funding streams for primary care and hospital services. Many children in California have greater access to health insurance coverage than their parents or than children in many other parts of the country because of county-level initiatives. The Children's Health Initiatives in some counties and communities provide health insurance coverage to all income-eligible children between birth and age five who are not otherwise eligible for Medi-Cal, including unauthorized immigrant children. Funding for these programs, which provide coverage similar to what was offered under Healthy Families, is provided by county First Five programs, which are funded through a state tobacco tax. Some programs have been able to temporarily fund health insurance for older children through a mix of public and private foundation funding, but insurance is generally not available for older unauthorized immigrant children in most counties. Another program, the Child Health and Disability Prevention Program Gateway,

provides all children in low-income families limited access to preventive checkups on a frequency schedule according to age, and up to two months of care following each checkup if necessary. The program aims to provide a pathway to Medi-Cal enrollment for eligible children, but children who are not eligible for Medi-Cal can use the gateway program for limited periodic health care access.

California's Successes in Connecting Immigrants to Health Insurance

California has taken many steps to increase immigrants' ability to access health insurance before and during ACA implementation. California has devoted considerable state and local financing to providing insurance to low-income immigrants who are ineligible for public insurance, particularly new LPRs, pregnant women and young children of all immigration statuses, and immigrants with particularly severe health challenges. Even prior to 2014, the state had already connected some residents—including longer-term LPRs, who are newly eligible for public insurance under the ACA—to temporary public insurance options through county-run LIHPs. Below we describe some of the state's other efforts that could help connect immigrants to health insurance.

Addressing Medi-Cal churning and mixed eligibility within immigrant families. California's proposed Bridge Plan to address churning in and out of Medicaid could benefit many immigrant families in California, who are disproportionately likely to be low income. Providing lower-income lawfully present immigrant parents with the same low-cost health insurance as their children, with lower premiums than they would face through Covered California, would lower the cost burden of insurance for these families. Ensuring that parents and children have access to the same providers under the same plan could greatly improve families' ability to locate health care providers and access services by reducing transportation and other logistical challenges that are often particularly severe for immigrant families.

Outreach. In recent decades, California has conducted outreach and application assistance aimed at increasing the enrollment of immigrant and limited English proficient populations in its public health insurance system. California's enrollment program for the recently eliminated Healthy Families (CHIP) program enlisted various nonprofit agencies, including some focused on serving immigrant populations, to serve as enrollment entities (EEs). Within EEs, individuals could become certified application assistants (CAAs) by completing a five-hour web-based training course and passing an online exam. CAAs were enlisted primarily to help eligible children enroll in Healthy Families, but they also enrolled eligible children in Medi-Cal. EEs have been able to use community connections and staff language skills to enroll immigrant community members in health insurance. This experience likely prepared organizations to conduct similar outreach in immigrant communities for Covered California.¹³ Covered California's enrollment assistance Navigators, required under the ACA, are funded by both per-application payments and grants. Navigators will help ensure that hard-to-reach geographic areas and subsets of the population are served (Covered California 2013).

Language access. California has translated outreach materials and information about available health insurance programs into a wide variety of languages for many years. California law requires that Medi-Cal agencies provide language assistance in any language needed by 3,000 enrollees or 5 percent of the enrollee population, whichever is lower. Such languages are considered “threshold languages.” California is actively working with Covered California and the provider of the eligibility system for the state marketplace to facilitate eligibility screening in all threshold languages and to provide broad language access in online, telephone, and written communication. The private company managing California’s Medi-Cal managed care enrollment process monitors language demand for call centers and hires for language skills as needed.

Finally, California has extensive experience developing application materials and processes that address immigrants’ sensitivities and challenges. Streamlined Medi-Cal and Covered California application forms clearly state that applicants need only provide Social Security numbers for people who are applying for insurance; the forms also explain that parents can apply for their children even when parents are ineligible for coverage. The forms further state that applying for public insurance for their children does not hurt immigrants’ chances of becoming permanent residents or citizens.

Challenges for Immigrant Inclusion

Despite these strengths, there are a number of reasons immigrants in California might remain without insurance after the ACA is fully implemented.

Costs for lower-income families. The cost of insurance could remain out of reach for lawfully present immigrants who are not eligible for Medi-Cal. Such immigrants are now eligible to purchase insurance through Covered California, with their share of the cost of the insurance premium capped on a sliding scale from 2 percent of family income for those with incomes at or below 133 percent of FPL to 9.5 percent for those with incomes at 400 percent of FPL. But some advocates and service providers are concerned that paying nearly 10 percent of family income for health insurance may be burdensome for lower-income families, who may choose to allocate income to other necessities instead.

Outreach and enrollment assistance challenges. Service providers we spoke with in California were concerned about an apparent lack of state coordination of enrollment outreach plans. They feared that without coordination, outreach efforts would not reach all geographic areas or all immigrant and language groups. They worried that lower-incidence immigrant groups, those speaking less common languages, and those in rural areas of the state might not have access to outreach and application assistance. Additionally, per-application payments for enrollment assistance are limited to applications for Covered California, while many of the uninsured lawfully present immigrants in California are eligible for Medi-Cal. The lack of reimbursement for Medi-Cal application assistance could limit outreach to immigrant populations.

Enrollment assistance for immigrant families may require more time and effort than enrollment for other families because some immigrants see public insurance as stigmatized, some are misinformed about eligibility requirements, and some falsely believe that accessing Medi-Cal could hurt their

chances of later obtaining LPR status or citizenship. The need for better information is often compounded by the fact that some immigrant families face complicated mixes of insurance eligibility within the same family due to different immigration statuses, ages, and durations of residence. In particular, unauthorized immigrant parents whose children are eligible for Medi-Cal or Covered California may assume their children are ineligible, or they may be reluctant to fill out the paperwork required to apply for child-only insurance for their children.

Conducting outreach and providing assistance to all of California's diverse language groups is an ongoing challenge. Outreach efforts involve many forms of media, including brochures, print ads, radio and television ads, and information sessions, and applications may be completed online, by mail, by phone, or in person. Translating all forms of messaging, application materials, and assistance into all threshold languages may not be feasible. In addition, some immigrant populations have limited literacy in their native languages, making even translated materials potentially inaccessible.

Accommodating immigrants in the integrated eligibility verification system, called the California Healthcare Eligibility, Enrollment, and Retention System (CalHEERS), may present challenges. Under the ACA, applicants seeking health insurance, whether through Medi-Cal or the state marketplace, apply through one streamlined system that can automatically verify eligibility through queries to immigration databases and the Social Security Administration. The system is designed to be easily accessible online, though applicants may also apply by phone, by mail, or in person. Immigrants, however, may not have the documents required by the system for verifying immigration status, income, or residency. For example, some lawfully present immigrants who are eligible for Medi-Cal based on their immigration status do not have Social Security numbers,¹⁴ but many systems are not set up to facilitate enrollment in these situations, and many agency workers may not be trained to handle more complicated applications. Likewise, plans for how CalHEERS will verify the income of unauthorized parents applying for benefits for their children are still being completed. Parents who are unauthorized immigrants may not have a Social Security number or a taxpayer ID number, or they may not have reported income or used their own name to pay federal taxes (although many unauthorized immigrant workers do pay such taxes). Immigrants may not wish to provide information about the incomes of all members of the family or household for fear of exposing unauthorized immigrants in their household to the government. Applicants can opt out of automated immigration and income verification processes and opt for manual verification instead, but it remains unclear whether this option will be widely understood.

Provider shortages. Interviews revealed worries that there are not enough doctors accepting Medi-Cal patients. California has one of the lowest payment rates for Medicaid providers, and it is implementing a further 10 percent reduction in Medi-Cal payment rates. Respondents reported that many doctors are reluctant to accept Medi-Cal because of these low rates and stigma associated with Medi-Cal. Shortages of Medi-Cal doctors could become more severe as increasing numbers of Californians obtain Medi-Cal coverage and seek health care; these shortages may be particularly severe for immigrant communities in poor neighborhoods or rural areas where doctors may be reluctant to work and live. The temporary increase in primary care reimbursements in Medicaid under the ACA in

2013–14 could provide some relief for providers, though California did not implement the higher payments until November 2013, retroactive to the beginning of the year.

Lessons from California

California's policy decisions related to the ACA have been made within a specific context: the state has a particularly large immigrant population, long-term experience with a sizable population of unauthorized immigrants, a large population spread across a broad geographic area, and a large budget. Although state-to-state conditions vary, California's efforts to include immigrants within its plans for the ACA highlight important considerations for other states weighing impacts on immigrants alongside other costs and benefits of new health policy decisions.

California has learned to address the special complexities involved in enrolling immigrants in public health insurance programs, including accommodating foreign language needs, limited literacy, and documentation challenges. Key to this work has been reliance on community groups who can conduct outreach and help immigrants with the application process and materials, as well as strong efforts within government agencies to hire staff with foreign-language skills and translate materials into relevant languages. California is also working to provide outreach to places and populations that are difficult to reach by offering grant-based funding for application and enrollment assistance.

Covered California designed enrollment and eligibility verification systems that seem like they will function well for immigrant families containing complicated mixes of eligibility, who may lack complete documentation for all family members. The state also allows multiple modes of application to accommodate populations without regular access to the Internet or a stable phone number, as well as those who have difficulty filling out paper forms because of language and literacy barriers. Applications that allow ineligible parents to apply for insurance for their children could particularly improve the ability of immigrants in the state to obtain new insurance under the ACA.

California's proposed Bridge Plan would help ensure continuity of coverage for families churning in and out of Medicaid because of income fluctuations. Rather than create a separate Basic Health Plan for those at the border of Medi-Cal eligibility, the Bridge Plan would allow families to maintain coverage under the same managed care plan as they fluctuate in and out of Medi-Cal eligibility. This plan would also allow more parents and children to access care through the same managed care system. If implemented, this approach could enable better insurance coverage for all low-income families in California, including immigrant families.

California has made creative use of available federal, state, and local funds to meet state policy goals in providing health insurance to some subgroups of the immigrant population. For example, drawing on federal CHIP funding, a state tobacco tax, other state and county funds, and private funding, California has found ways to finance health insurance coverage and access to health care for very young unauthorized immigrant children, pregnant women, individuals seeking family planning services, and men and women with certain types of cancer. Some counties, such as San Francisco, have even been able to provide access to basic health care for all low-income residents.

California, like other states, will continue to face challenges in ensuring that those with Medicaid and those who remain uninsured will have access to primary care and follow-up care for health conditions. Ensuring an adequate supply of primary care providers will likely be an ongoing challenge for California and other states. Since immigrants are likely to form a disproportionate share of the residually uninsured after the ACA is fully implemented, they may be particularly affected by a restricted supply of primary care providers under the public safety net systems. Further, the language skills and cultural competencies of these providers will affect the quality of care accessed by immigrants in California and across the country.

Appendix. Definitions

Foreign-born: Someone born outside the United States and its territories, except those born abroad to US-citizen parents. The foreign-born include those who have obtained US citizenship through naturalization and people in different immigration statuses. People born in the United States, Puerto Rico, and other territories, or born abroad to US-citizen parents, are native-born.

Immigrant: A foreign-born person who is not a citizen of the United States as defined by the Immigration and Nationality Act, Section 101 and the following (similar to the statutory term “alien”). This definition of immigrant is narrower than some common definitions that treat any foreign-born person as an immigrant, including those who have become naturalized citizens. Since a central focus of this study is on immigrant eligibility, and citizenship is a key factor in determining eligibility for benefit programs, this brief adheres to the legal definition of immigrant.

Lawful permanent residents (LPRs): People lawfully admitted to live permanently in the United States by either qualifying for immigrant visas abroad or adjusting to permanent resident status in the United States. Many but not all LPRs are sponsored (i.e., brought to the United States) by close family members or employers.

Naturalized citizens: LPRs who have become US citizens through naturalization. Typically, LPRs must be in the United States for five or more years to qualify for naturalization. Immigrants who marry citizens can qualify in three years, and some smaller categories can qualify sooner. LPRs generally must take a citizenship test—in English—and pass background checks before qualifying to naturalize.

Refugees and asylees: People granted legal status because of persecution or a well-founded fear of persecution in their home countries. Refugee status is granted before entry to the United States. Asylees usually arrive in the United States without authorization (or overstay a valid visa), claim asylum, and are granted asylee status once their asylum applications are approved. Refugees and asylees are eligible to apply for permanent residency after one year.

Undocumented or unauthorized immigrants: Immigrants who are not LPRs, refugees, or asylees and have not otherwise been granted permission under specific authorized temporary statuses for lawful residence and work.

Lawfully present immigrants: Lawfully present immigrants include LPRs, refugees, and asylees, as well as other foreign-born persons who are permitted to remain in the United States either temporarily or indefinitely but are not LPRs. Some lawfully present immigrants have entered for a temporary period for work, as students, or because of political disruption or natural disasters in their home countries. Some may seek to adjust their status and may have a status that allows them to remain in the country but does not grant the same rights as LPR status. The term “lawfully present” is used for applying for Title II Social Security benefits and is defined in the Department of Homeland Security regulations at 8 CFR 103.12(a). The same definition is also used by the US Department of Agriculture for determining eligibility for food stamp benefits. In 2010, the Centers for Medicare and Medicaid issued guidance to states that further defined “lawfully present” for determining eligibility for Medicaid and CHIP benefits under the Children’s Health Insurance Program Reauthorization Act of 2009.

Qualified immigrants: The following foreign-born people are considered eligible for federal benefits:

- LPRs
- refugees
- asylees
- people paroled into the United States for at least one year
- people granted withholding of deportation or removal
- people granted conditional entry (before April 1, 1980)
- battered spouses and children (with a pending or approved spousal visa or a self-petition for relief under the Violence Against Women Act)
- Cuban and Haitian entrants (nationals of Cuba and Haiti who were paroled into the United States, applied for asylum, or are in exclusion or deportation proceedings without a final order)
- victims of severe human trafficking (since 2000, victims of trafficking and their derivative beneficiaries [e.g., children], are eligible for federal benefits to the same extent as refugees and asylees)

Nonqualified immigrants: Immigrants who do not fall into qualified immigrant groups, including immigrants formerly considered permanently residing under color of law, immigrants with temporary protected status, asylum applicants, other lawfully present immigrants (such as students and tourists), and unauthorized immigrants.

Five-year ban: Under TANF, SNAP, Medicaid, and CHIP, post-enactment qualified immigrants, with important exemptions, are generally banned from receiving federal means-tested benefits during their first five years in the United States.

Notes

1. This brief was written in late 2013 and early 2014 and may not reflect the most recent shifts in federal and California health policy.
2. Under this project, “immigrants” refers to foreign-born persons who have not naturalized, who are not US citizens. See the appendix for a definition of terms used in this brief.
3. The eligibility threshold is generally stated as 133 percent of FPL, but it is effectively 138 percent since 5 percent of income is disregarded when determining eligibility. The federal government will cover 100 percent of the cost of Medicaid for the newly eligible population for 2014–17, 95 percent in 2017, 94 percent in 2018, 93 percent in 2019, and 90 percent in 2020 and thereafter.
4. See the definition of “qualified immigrants” in the appendix.
5. State health insurance marketplaces are often called “exchanges.” Marketplaces (exchanges) offer a set of government-regulated health insurance policies, generally offered by private companies.
6. See the definition of “lawfully present” in the appendix. This category is slightly broader than the category of “qualified immigrants”—the category of immigrants who may be eligible for Medicaid if they meet income criteria.
7. Patient Protection and Affordable Care Act §1311(i), 42 USC § 18001 et seq. (2010).
8. “Health Centers to Help Uninsured Americans Gain Affordable Health Coverage,” US Department of Health and Human Services press release, July 10, 2013, <http://www.hhs.gov/news/press/2013pres/07/20130710a.html>.
9. Insurance is not yet available through the Bridge Plan in 2014, and details of the proposed plan are still in the works.
10. Unauthorized immigrants and other noncitizens who are ineligible for Medi-Cal, but have incomes that would otherwise make them eligible, remain eligible for emergency Medi-Cal. Emergency Medi-Cal covers the cost of emergency medical care during life-threatening situations.
11. Pre-Existing Condition Insurance Plan Program, 77 Fed. Reg. 52,614 (Aug. 30, 2012). DACA recipients are also barred from accessing federally funded Medicaid and CHIP under the state option to cover “lawfully residing” children and pregnant women: <http://www.medicaid.gov/Federal-Policy-Guidance/downloads/SHO-12-002.pdf>. Those granted deferred action through other channels retain the same eligibility for Medi-Cal that they had before the ACA (NILC 2012).
12. This includes prenatal care, delivery, and limited postpartum care for pregnant women; the Every Woman Counts program to provide free breast and cervical cancer screenings to women; the Breast and Cervical Cancer Treatment Program to provide cancer treatment to women; the IMPACT program to provide screening and treatment for prostate cancer; the AIDS Drug Assistance Program to provide access to medication for people living with HIV/AIDS; the Major Risk Medical Insurance Program for individuals unable to obtain insurance because of a preexisting condition; California Children’s Services for children in low-income families with major illnesses; Family Planning, Access, Care, and Treatment to provide access to family planning services for low-income men and women; the Access for Infants and Mothers program for prenatal and infant care for middle-income women ineligible for no-cost Medi-Cal; and the Genetically Handicapped Person Program for adults with certain genetic diseases. These programs are expected to continue.
13. For more on how other states are using their experience conducting outreach about CHIP to design outreach on available insurance under the ACA, see Hill, Courtot, and Wilkinson (2013).
14. For example, those in the process of applying for visas based on being a victim of crime or experiencing domestic violence.

References

- Brindis, Claire D., Max W. Hadler, Ken Jacobs, Laurel Lucia, Nadereh Pourat, Marissa Raymond-Flesch, Rachel Siemons, and Efrain Talamantes. 2014. *Realizing the Dream for Californians Eligible for Deferred Action for Childhood Arrivals (DACA): Demographics and Health Coverage*. Los Angeles: UCLA Center for Health Policy Research.
- California Department of Health Care Services. 2011. *California's Bridge to Reform Demonstration - Low Income Health Program*. Sacramento: California Department of Health Care Services. <http://www.dhcs.ca.gov/provgovpart/Documents/LIHP/LIHP%20Fact%20Sheet.pdf>.
- Covered California. 2013. "Covered California Assistors Program: In-Person Assistance and Navigator Webinar." West Sacramento: Covered California. <http://www.healthexchange.ca.gov/Stakeholders/Documents/Assistors%20Webinar%20FINAL02072013.pdf>.
- DeNavas-Walt, Carmen, Bernadette D. Proctor, and Jessica C. Smith. 2012. *Income, Poverty, and Health Insurance Coverage in the United States: 2011*. Suitland, MD: Census Bureau.
- Hill, Ian. 2012. *Cross Cutting Issues: Will There Be Enough Providers to Meet the Need? Provider Capacity and the ACA*. Washington, DC: Urban Institute. <http://www.urban.org/publications/412700.html>.
- Hill, Ian, Brigitte Courtot, and Margaret Wilkinson. 2013. *Reaching and Enrolling the Uninsured: Early Efforts to Implement the Affordable Care Act*. Washington, DC: Urban Institute. <http://www.urban.org/publications/412917.html>.
- Insure the Uninsured Project. 2013. *ObamaCare 101 Tool Kit*. Santa Monica, CA: Insure the Uninsured Project.
- Kenney, Genevieve M., and Michael Huntress. 2012. "The Affordable Care Act: Coverage Implications and Issues for Immigrant Families." ASPE Issue Brief. Washington, DC: Office of the Assistant Secretary for Planning and Evaluation. <http://www.urban.org/publications/413262.html>.
- Kenney, Genevieve M., Stephen Zuckerman, Lisa Dubay, Michael Huntress, Victoria Lynch, Jennifer Haley, and Nathaniel Anderson. 2012. *Opting in to the Medicaid Expansion under the ACA: Who Are the Uninsured Adults Who Could Gain Health Insurance Coverage?* Washington, DC: Urban Institute. <http://www.urban.org/publications/412630.html>.
- Migration Policy Institute. 2013. *2011 American Community Survey and Census Data on the Foreign Born by State*. Washington, DC: Migration Policy Institute. <http://www.migrationinformation.org/datahub/acscensus.cfm>.
- NILC (National Immigration Law Center). 2012. *"Lawfully Present" Individuals Eligible under the Affordable Care Act*. Washington, DC: NILC.
- Passel, Jeffrey S., and D'Vera Cohn. 2011. *Unauthorized Immigrant Population: National and State Trends, 2010*. Washington, DC: Pew Research Center.
- Perreira, Krista M., Robert Crosnoe, Karina Fortuny, Juan Manuel Pedroza, Kjersti Ulvestad, Christina Weiland, Hirokazu Yoshikawa, and Ajay Chaudry. 2012. "Barriers to Immigrants' Access to Health and Human Services Programs." ASPE Research Brief. Washington, DC: Office of the Assistant Secretary for Planning and Evaluation. <http://www.urban.org/publications/413260.html>.
- Sommers, Benjamin D., and Sara Rosenbaum. 2011. "Issues in Health Reform: How Changes in Eligibility May Move Millions Back and Forth between Medicaid and Insurance Exchanges." *Health Affairs* 30 (2): 228–36. doi:10.1377/hlthaff.2010.1000.

About the Authors

Julia Gelatt is a research associate in the Center on Labor, Human Services, and Population at the Urban Institute. In addition to analyzing the Affordable Care Act's implications for immigrants, Gelatt's work on immigration includes a review of promising practices for connecting immigrant families to prekindergarten, a description of the limited English proficient population in Washington, DC, and research on the implications of parents' and children's immigration status for children's health and well-being. Her work uses mixed methods, including secondary data analysis, original survey development, administrative data analysis, and qualitative interviews.

Heather Koball is a senior fellow in the Center on Labor, Human Services, and Population, where her areas of expertise include immigration and at-risk youth. Koball has directed multiple projects on issues faced by children of immigrants, including a study of the well-being of children whose families have been affected by immigration enforcement, access to public benefits among immigrant families, the implications of the Affordable Care Act for immigrants' health care, and immigrant integration in new destination areas.

Juan Manuel Pedroza is a doctoral candidate in sociology at Stanford University. When working on this project, he was a research associate at the Urban Institute, where he focused on immigration and the US social safety net. He has conducted field research and analyses of policies and programs affecting low-income families. Pedroza is currently analyzing the determinants and consequences of immigration enforcement across the United States.

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