CONNECTICUT VOICES FOR CHILDREN

National Health Insurance Reform: Opportunities and Challenges for Connecticut's Immigrant Families

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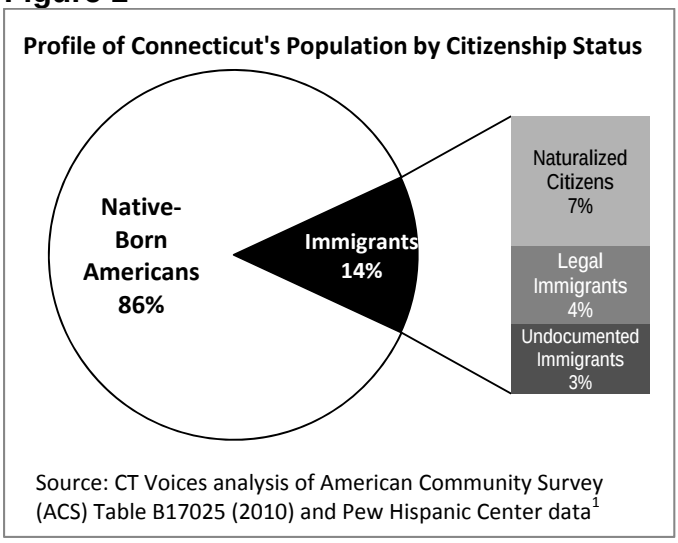
The health insurance landscape has shifted significantly over the last few years, with many developments that affect immigrants. Some changes arose as a result of national legislation, including the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA) and the Patient Protection and Affordable Care Act (ACA). Other changes occurred due to state-level budget cuts and court challenges to those cuts. Collectively, these developments have resulted in changes to enrollment practices, benefits, insurance costs, and covered populations. While some of these new policies have already been implemented, others will not take effect until 2014 or later. This issue brief addresses these recent and forthcoming developments in health insurance access and coverage for Connecticut's immigrant population.

Key Findings

- **The individual mandate and affordability provisions of the ACA will increase coverage**
- **The Medicaid expansion for low income adults will increase access to affordable coverage for many immigrants**
- **The health insurance exchanges will increase access for many immigrants who lack employer-sponsored coverage**
- **Subsidies to purchase exchange coverage will make insurance more affordable for low-income recent immigrants who are ineligible for Medicaid**
- **The Basic Health Program option could increase coverage options and affordability for low income immigrants**
- **Streamlined eligibility and verification procedures will help more immigrants enroll in and maintain coverage**
- **Undocumented immigrants will experience no changes to their limited options**

Figure 1



Source: CT Voices analysis of American Community Survey (ACS) Table B17025 (2010) and Pew Hispanic Center data[1]

Immigrants disproportionately experience barriers to health coverage. An immigrant may or may not be eligible for state and federal programs, depending on immigration status. Barriers to private coverage and access – such as poverty and lack of English proficiency – also contribute to disparities.

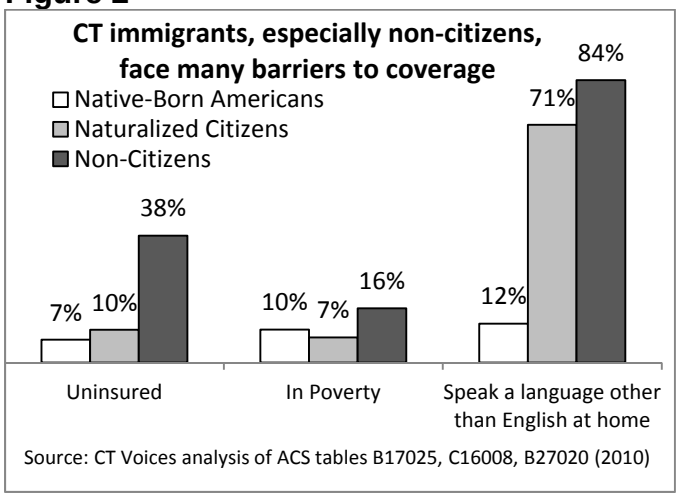
Immigration status affects eligibility for publicly funded health benefits. Data from the US Census Bureau provide a profile of Connecticut's immigrant population (Figure 1).[1] Naturalized citizens – those who were born in another country but have become US citizens – are treated on par with native-born citizens for the purposes of eligibility for government health insurance. Legal Permanent Residents (LPRs) qualify for the same subsidies and programs as American citizens but only after they have been US residents for 5 years. However, in Connecticut, the residency requirement is waived for some categories of LPRs (pregnant women and children) through the state's election of a federal option; these LPRs are immediately eligible for services. Asylees, refugees,

and certain other special categories of immigrants are also eligible without a 5 year waiting period.[2] Undocumented immigrants (including those who entered the country illegally and those who entered the country legally but overstayed their visas) are barred from nearly every federal and state health insurance program.

Health Insurance a Struggle for Many of Connecticut's Immigrants

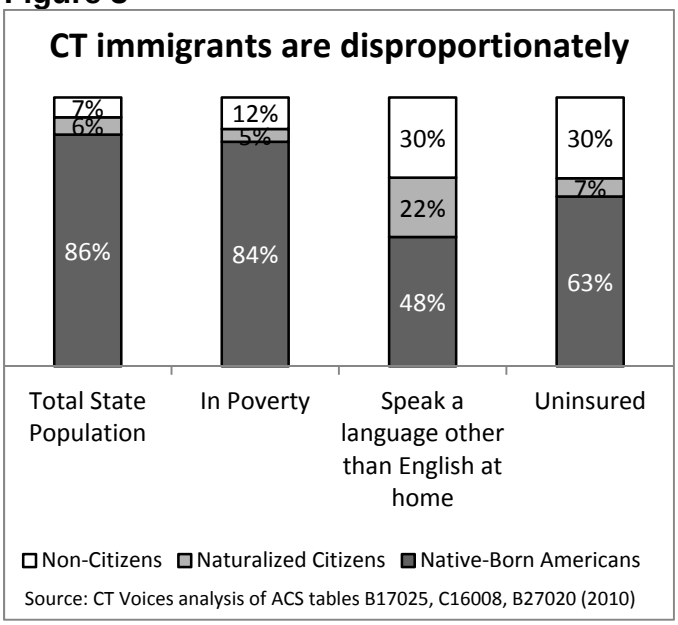
Access to health insurance is a challenge for immigrants. They face a number of barriers to receiving health care, including low rates of insurance, limited English proficiency, and high levels of poverty (Figure 2).

Figure 2



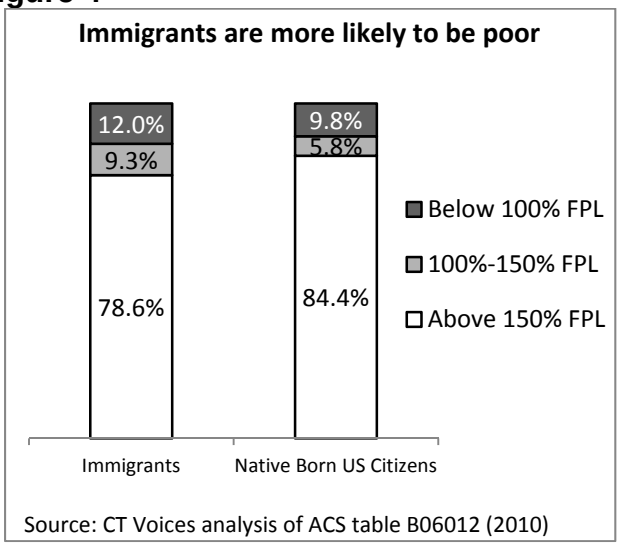
Non-citizens (LPRs and undocumented immigrants) are particularly at risk of lacking insurance. In Connecticut, 38 percent are uninsured, compared to 7 percent of native-born citizens and 10 percent of naturalized citizens. This is due in large part to ineligibility for federal and state subsized care. Undocumented immigrants are barred from nearly every governmental insurance program, and most legal permanent residents must have been US residents for 5 years to receive many government services. Other barriers to enrollment, such as poverty and lack of English language ability, also contribute to the high uninsurance rate.

Figure 3



A relatively small proportion of Connecticut residents are immigrants (only 14%), but they account for large portions of Connecticut's at-risk populations, particularly persons who speak a language other than English at home and the uninsured (Figure 3).

Figure 4



Immigrants in Connecticut are also more likely to be in poverty than other Connecticut residents. Twelve percent of immigrants fall below the Federal Poverty Level (FPL) and 21 percent are at or below 150 percent of the FPL (Figure 4). Finally, while immigrants are as likely as native-born citizens to

work, they are more likely to be self-employed, work in small firms, engage in seasonal employment, or hold low-income jobs without health benefits, all of which contribute to a much lower rate of employer-sponsored health insurance coverage.[3]

Certain Recent Immigrants Lose Access to Coverage

The federal government treats naturalized and native-born US citizens equally in terms of access to federal benefits, such as the Supplemental Nutrition Assistance Program (SNAP) and Medicaid. However, since 1996, immigrants who are lawful permanent residents (LPRs) but have not attained citizenship do not become eligible for federal assistance programs until they have been US residents for five years.

Connecticut, through the State Medical Assistance for Noncitizens Program, provided health insurance coverage to low-income adults who would otherwise have been eligible for Medicaid but did not qualify because of the federal residency requirement. The state legislature defunded this program in 2009 because of budget pressures. Legal aid groups representing the approximately 4,700 people losing coverage filed a lawsuit.[4] They won in state Superior Court, temporarily protecting these recent immigrants' health care coverage. But, in April 2011, the state Supreme Court overturned the lower court ruling, concluding that Connecticut could defund the program and did not have an obligation to provide state-funded health care to this population.[5] As a result, certain low-income recent immigrants no longer receive state-sponsored health insurance in Connecticut.

Pregnant Women and Children Retain HUSKY Coverage

Beginning in 2009, federal law under CHIPRA gave states the option to cover immigrant children and pregnant women under Medicaid and CHIP without the five year residency requirement.[6] CHIPRA also lifted the sponsor deeming requirement for these populations in states taking up the coverage option. This change effectively lowers the calculated income for affected individuals, increasing the number of people eligible for the programs or making current recipients eligible for higher levels of subsidy.[7]

Prior to 2009, Connecticut used state funds to cover children and pregnant women who were ineligible for Medicaid and CHIP because of an insufficient period of residency in the US. After the passage of CHIPRA, the state elected the new federal coverage option and began to receive federal matching funds for health care provided to recent immigrant children and pregnant women.[8] This increase in access to federal funds helped ensure that these groups retained health coverage despite the budget cuts that eliminated similar coverage for non-pregnant adults in 2009.

Medicaid for Low Income Adults Increases Access to Coverage

Under the ACA, states must extend Medicaid eligibility to childless adults up to 133 percent of the FPL by January 2014, and have the option to begin covering them before that date. Connecticut has historically covered childless adults up to 56 to 68 percent of the FPL (depending on where they lived) entirely with state funds through the State-Administered General Assistance (SAGA) medical program.[9] Starting April 1, 2010, Connecticut became the first state in the nation to elect the new federal option, moving 45,000 single, very poor adults previously in the state-funded plan onto Medicaid. This change allows the state to receive a 50 percent federal Medicaid reimbursement for the cost of covering this group.[10] This program was renamed Medicaid for Low-Income Adults (Medicaid-LIA). The program offers several improvements over SAGA, including no asset test for eligibility and yearly coverage renewal (instead of semi-annual), as well as access to some additional services, such as non-emergency medical transportation.[11,12]

Beginning in 2014, Connecticut will be required to cover all adults up to 133 percent of FPL through Medicaid, further expanding the pool of covered adults. The state will receive full federal funding for this expansion for the first three years, with federal reimbursement declining to 90 percent of the cost by 2020. It is estimated that this coverage expansion will increase Medicaid enrollment by 20 percent in Connecticut by 2019 and reduce the number of uninsured adults under 133 percent of FPL by 48 percent.[13]

Given the higher levels of poverty among immigrants, these recent and future Medicaid expansions will help many uninsured immigrants secure coverage. However, the federal five year bar remains a barrier to insurance for many poor recent immigrants.

Insurance Exchange Options Increase Access

The ACA created a framework for the establishment of insurance exchanges by January 2014, where individuals and small businesses without other coverage options may purchase health insurance. Naturalized citizens and LPRs (*including those subject to the 5 year bar to Medicaid eligibility*) will be able to purchase health insurance through these exchanges. They will also be eligible for federal subsidies to purchase coverage if they make less than 400 percent of FPL and they do not have access to comprehensive, affordable employer-sponsored insurance.[14]

These new coverage options and subsidies provide a significant benefit to immigrants, in particular the very poor who do not qualify for Medicaid because of the 5 year bar, and those who are near poor but do not qualify for Medicaid because their income is too high. However, *undocumented immigrants are not eligible for subsidies nor are they allowed to purchase insurance through the exchanges with their own money.*

Under the ACA, each state must also establish a small business exchange where companies with fewer than 100 employees can purchase group insurance plans. Many small businesses will be eligible for tax credits (for up to 35% of their share of the premiums) to help cover the cost of providing insurance for their workers.[15] These options will be especially helpful for immigrants, who are disproportionately likely to work for small firms, earn lower wages, and not have access to employer-sponsored health care.

Persons securing insurance through the exchanges will benefit not only from government subsidies, but also from increased options, expanded benefits, and reduced costs. The ACA encourages the formation of not-for-profit plans that may offer lower prices or higher quality than existing options. Furthermore, all plans offered in the exchange will be required to provide a broad array of preventive services with no cost sharing, including immunizations, screenings, contraceptive and family planning care, tobacco cessation treatment, and obesity reduction programs.[16] Out of pocket costs will be capped and cost sharing (such as co-pays and deductibles) will be lowered for low income purchasers.[17] While these improvements benefit all people utilizing the exchanges, they are particularly helpful to immigrants because of the higher poverty rates that will make more immigrants eligible for cost reductions, and because of increased access to preventive services, which immigrants are less likely to use.[18]

There is, however, a danger that Connecticut could move populations currently covered by Medicaid (parents earning 133% to 185% of the FPL and pregnant women earning 133% to 250% of the FPL) onto the exchanges. While this would save the state money (Connecticut currently pays 50% of the Medicaid costs for this group; the state would pay 0% of their exchange subsidy costs), it would increase costs for patients who currently have no premiums or co-payments in Medicaid and would face significant costs on the exchanges even with federal subsidies.

Basic Health Program May Improve Coverage for Certain Low-Income Adults

The Basic Health Program option in the ACA allows states to create a state-run, federally financed Medicaid-like health plan. This plan would cover essential health benefits and could offer lower co-payments and premiums than in the exchanges.[19] Advocates have suggested that it might even be possible for the Basic Health Program to provide Medicaid-level coverage with no cost-sharing.[20] If Connecticut were to implement such a Medicaid look-alike plan, this would allow individuals with income fluctuations near the Medicaid income limit to move more easily between Medicaid and the Basic Health Program, and for more parents to stay on the same plans as their children.

The plan would be available for individuals earning 133 to 200 percent of FPL, and would be available for immigrants making 0 to 200 percent of the FPL who are not eligible for Medicaid because of the 5 year residency requirement**.** States would receive 95 percent of the amount the federal government would

be paying for exchange subsidies for the covered population. This approach could significantly reduce costs for states like Connecticut that currently cover many of these people in Medicaid with only a 50 percent federal match.[21] States could also choose to move the entire population into the exchanges, for which the federal government provides 100 percent of the premium subsidies. These options are mutually exclusive – if the state offers a Basic Health Program, those eligible for the Basic Health Program are no longer eligible for Medicaid or exchange subsidies. Connecticut's Health Insurance Exchange Board has been tasked with evaluating the Basic Health Program option, but no final determination has been made about whether to adopt it.

The Basic Health Program would increase access and lower costs for some immigrants, while potentially raising costs and lowering access for others. Parents and pregnant women who are currently covered by Medicaid pay no premiums or co-payments. If a Basic Health Program were implemented, parents between 133 to 185 percent of the FPL and pregnant women between 133 to 200 percent of the FPL would be forced off of Medicaid and onto the new Basic Health Program, requiring them to pay potentially unaffordable premiums and co-payments. The transfer from Medicaid to a higher-cost Basic Health Program might increase the likelihood that affected individuals forgo insurance, exposing them to fines under the new individual mandate and greatly reducing their access to and use of care. For those with better and cheaper coverage through Medicaid, the Basic Health Program option would have a significant negative impact.

For low-income immigrants barred from Medicaid because of the 5 year residency requirement, however, the Basic Health Program offers an opportunity for increased access. The Basic Health Program would provide this group the chance for coverage at a lower cost than even the subsidized rates in the exchanges. This option is particularly helpful for immigrants who are under the federal 5 year bar and earning less than 133 percent of the FPL, for whom exchange coverage, even subsidized, is largely unaffordable.[22]

Individual and Employer Coverage Mandates Offer Benefits and Challenges

Under the ACA, starting in 2016, all individuals (including naturalized citizens and legal permanent residents regardless of period of residency) are required to purchase health insurance unless it would be a significant hardship to do so.[23] Those who remain uninsured would be subject to a fine, phased in beginning in 2014.[24] The law does not contain enforcement provisions for the fines, so it is unclear how successful the government will be in collecting them. Undocumented immigrants are not subject to the individual mandate. Medium- and large-employers whose employees receive premium tax credits to purchase insurance through exchanges, whether or not the employer offers health insurance, will be subject to penalties.[25]

This provision may hurt immigrants who do not qualify for subsidies or government health care, or for whom the cost of acquiring insurance is still burdensome even with subsidies. But, if more immigrants purchase or receive insurance coverage that enables them to access care, they will acquire significant health benefits. Compared to those without insurance, insured low-income non-citizens are vastly more likely to have a regular source of care, receive preventive care, and have seen a health provider in the last 2 years.[26] To the extent that the employer penalty for not offering affordable health coverage encourages more business to offer insurance or to lower prices for employees, this aspect of the mandate will be especially helpful to immigrants.

New Streamlined Verification and Enrollment Procedures May Increase Access to Coverage

The ACA requires states to improve the application process for Medicaid, CHIP, and premium credits for the exchanges. By January 1, 2014, all states must offer one streamlined form for all three programs and allow individuals to apply online, as well as by phone, in person, and by mail. States must also store eligibility information and reuse it to keep consumers enrolled, allow electronic submission of documents and verification of eligibility, and allow consumers to apply, renew, and edit eligibility information online.[27]

These changes are likely to help immigrants in a number of ways. The ability to apply 24/7, submit documentation online, and save a form and come back to it if questions or problems arise will allow more working people to apply for health care during non-working hours from their own homes and eliminate the need to re-enter information multiple times. Use of electronic systems will lower barriers to enrollment and reduce frustration that may lead immigrants to give up on applying. Furthermore, online applications can easily be offered in multiple languages, making them easier to complete for non-English-speaking applicants. The new system's requirement that states use all existing information to determine eligibility, including employment and income records will in many cases eliminate the need to provide paper copies of paystubs or W2 forms, again lowering the burden of enrollment.[28] Finally, the universal application for Medicaid, CHIP, and exchange subsidies will help maximize the number of people connected with appropriate services, notifying applicants for one program of their eligibility for others.

A 2006 law requiring Medicaid applicants to provide original documents that proved citizenship and identity resulted in many eligible US citizens losing coverage and greatly increased administrative hassle for states. As a result, under CHIPRA, the federal government created a Social Security Administration data match option which allows much faster and more accurate citizenship verification through the central SSA database; applicants can now submit a Social Security number, bypassing the need to provide original birth certificates and other potentially difficult-to-locate documents. All states will be required to implement this data match program by 2014 for the state insurance exchanges, but many states, including Connecticut, have already instituted it for CHIP and Medicaid with great success.[29]

LPRs and other non-citizens verify their statuses through the Systematic Alien Verification for Entitlements (SAVE) Program. This web-based system checks passport and immigration documents against information in a central Department of Homeland Security database and can provide immediate approval for more than 90 percent of applicants.[30]

Applicants whose information is not verified in the SSA or SAVE data match have 90 days to produce alternative documentation proving their citizenship status and remain insured during this period.

In general, immigrants should experience no more hassles and delays than under the previous system, and may benefit from faster processing as administrators' time is freed up from citizenship verification for the vast majority of applicants, allowing them to focus on the small number of problematic applications. This system does effectively bar undocumented immigrants from applying for coverage under CHIP, Medicaid, and the state insurance exchanges.

Presumptive Eligibility Improves Access to Coverage and Care

Presumptive eligibility allows states to immediately enroll children and pregnant women who appear to be eligible for CHIP or Medicaid rather than delaying care until an eligibility determination is made. Qualified entities, including schools and organizations that connect families with other government programs, such as Head Start, Care4Kids, WIC and federal housing assistance, may conduct the enrollment process and notify those seeking other services of their potential eligibility for insurance coverage.[31] This expedited process and expanded pool of enrollers helps get more people enrolled and ensure continuity of care and prompt access to services for the most vulnerable populations, including immigrants.

Connecticut implemented presumptive eligibility for children in Medicaid in 2006 and expanded the program to include pregnant women in 2009 and children in CHIP in 2011. Connecticut's program utilizes a common application form for presumptive eligibility and regular enrollment in Medicaid and CHIP. The universal form, coupled with the enhanced SSA and SAVE verification and use of existing state databases to determine income, often allows a transition from presumptive eligibility to full coverage without further action by the families.

Presumptive eligibility is beneficial to immigrants for a number of reasons. It makes enrollment faster, providing needed medical care sooner. Qualified entities can help recommend application for coverage to immigrants who may have been unaware they qualified for Medicaid or CHIP, or may not have applied because of a lack of access to documentation or confusion about the application process. The streamlined process is particularly helpful for undocumented parents who might not know that they can apply for coverage for their children without disclosing their own immigration status, or who incorrectly fear investigation by federal immigration officials if they apply.

Other Benefits under the ACA

The Affordable Care Act includes a number of other provisions that are particularly helpful for immigrants. The ACA appropriates $11.5 billion over five years to expand community based health centers, which provide services predominately in underserved areas and without respect to insurance status, citizenship, or ability to pay. This will be beneficial for immigrants, particularly those who are poor and undocumented, who disproportionately receive care from these facilities.[32] It also provides $1.5 billion to recruit minority health care workers for an expanded National Health Services Corps. These workers will help improve cultural competency and reduce language barriers to coverage for immigrants.[33]

Additionally, the ACA makes a number of changes that improve health insurance quality for all Americans, including immigrants. Some changes have already taken effect, while others are not effective until 2014. These provisions include:

- Requiring private insurances to allow young adults to remain on their parents' plans until age 26
- Requiring states to cover former foster youth on Medicaid until age 26
- Prohibiting denial of coverage because of pre-existing conditions
- Ending lifetime and annual limits on coverage
- Banning individual and group plans, and Medicaid from charging co-payments for preventive care
- Prohibiting "gender rating" in many insurance plans, thereby lowering the price of insurance for women

Undocumented Immigrants Continue to Lack Coverage Options

Despite many recent insurance improvements for naturalized citizens, certain legal permanent residents, and other legal immigrants, undocumented immigrants continue to face tremendous barriers to insurance coverage and access to health care. They will not be subject to the ACA's personal insurance mandate. But, they are blocked from purchasing coverage in the insurance exchanges, even if they do so without government assistance and with their own money. Undocumented persons also remain barred from participation in Medicaid and CHIP. The citizenship and immigration computer verification procedures are highly effective at enforcing these exclusions. However, it is important to note that children born in the US to undocumented parents are full citizens with access to health insurance coverage through HUSKY even though their parents ineligible.

The federal Emergency Medical Treatment and Labor Act (EMTLA) requires hospitals to provide stabilizing treatment for individuals with emergency medical conditions (including labor and delivery) regardless of ability to pay. It applies not only to US citizens and legal permanent residents, but also undocumented immigrants and legal immigrants with fewer than 5 years of US residency. Emergency Medicaid provides reimbursement to hospitals and other providers for emergency care to undocumented and legal immigrants with under 5 years of US residency if the patients otherwise meet the Medicaid income and categorical eligibility requirements.

Many of the changes to the private insurance market, such as expanded dependent coverage to age 26 and bans on denial of coverage for pre-existing conditions or lifetime coverage caps, will be beneficial for undocumented immigrant families with non-government-sponsored or non-subsidized coverage. The increased funding for community health centers is especially beneficial for undocumented immigrants, who depend heavily on safety net providers, including

community health centers, for care.[34] Nonetheless, on the whole, national health reform failed to offer significant improvements to health care access or insurance affordability for undocumented immigrants.

National Health Reform: Improving Health Care Access for Most Immigrants

Changes to state and national health policy, in particular national health reform, have resulted in significant improvements in cost and access to insurance for many immigrants. Low income adults, women, children, and those employed by small businesses have new opportunities for insurance through Medicaid, CHIP, and federally-subsidized insurance exchanges. All legal immigrants will benefits from streamlined enrollment procedures, including online multi-program applications and expedited verification processes. These new lower- and no-cost insurance options and streamlined application protocols should help more immigrants obtain insurance and stay enrolled, increasing health care utilization and improving health outcomes.

Many low-income recent immigrant adults – who remain ineligible for Medicaid for the first five years of residence – and undocumented immigrants – who are permanently ineligible for all federal and state programs – were largely unaided by national health reform. Undocumented immigrants will likely continue to struggle with lack of affordable insurance options. But, with the opening of the insurance exchanges, outlooks will soon improve for LPRs, who will be eligible to purchase coverage and receive subsidies.

Overall, national health reform should help most immigrants attain and maintain health insurance, and increase the quality of that insurance. However, it remains to be seen how all the provisions of the reform get carried out, and whether legal challenges to the Affordable Care Act overturn or undermine key provisions of the law. And much remains to be done to improve affordability and access to care for undocumented residents.

State- and Federally-Subsidized Health Insurance Options for Immigrants in Connecticut

Children

Populations listed below include naturalized US citizens, legal permanent residents (LPRs), and special categories of immigrants including refugees and asylees but NOT undocumented immigrants unless noted. Bolding indicates new coverage options as a result of federal health reform

Population	**Income Requirement**[35]	**Coverage Options – 2011** ***Cost-sharing information is current as of October 2011, but is subject to change prior to 2014***	**Coverage Options – 2014** ***Cost-sharing information listed is October 2011 coverage for that program, but levels may change significantly by 2014. Only preventive services are guaranteed to remain exempt from cost-sharing***
Children under age 19	Under 185% of FPL	HUSKY A (Medicaid) – Medical, dental, and behavioral health coverage without copays or premiums[36]	HUSKY A (Medicaid) – Medical, dental, and behavioral health coverage without copays or premiums
	Between 185%-235% of FPL	HUSKY B (CHIP) – No premiums, some co-pays	HUSKY B (CHIP) – No premiums, some co-pays
	Between 235%-300% of FPL	HUSKY B (CHIP) –Premiums of $30-$50/month, some co-pays	HUSKY B (CHIP) –Premiums of $30-$50/month, some co-pays
	Over 300% of FPL	HUSKY B (CHIP) – Un-subsidized premiums of $195/month, some co-pays	HUSKY B (CHIP) – Un-subsidized premiums of $195/month, some co-pays

Parents and Pregnant Women

Populations listed below include naturalized US citizens, legal permanent residents (LPRs), and special categories of immigrants including refugees and asylees but NOT undocumented immigrants unless noted. Bolding indicates new coverage options as a result of federal health reform

Population	Income Requirement	Coverage Options – 2011 *Cost-sharing information is current as of October 2011, but is subject to change prior to 2014*	Coverage Options – 2014 *Cost-sharing information listed is October 2011 coverage for that program, but levels may change significantly by 2014. Only preventive services are guaranteed to remain exempt from cost-sharing*
Parents or relative caregivers of children under 19 (including LPRs only if they have been US residents for over 5 years)	Under 133% of FPL[37]	HUSKY A (Medicaid) – Medical, dental, and behavioral health coverage without copays or premiums	**HUSKY A (Medicaid for Children and Families) or new HUSKY D (Medicaid-LIA)[38] – Medical, dental, and behavioral health coverage without copays or premiums[39]**
	Between 133%-185% of FPL	HUSKY A (Medicaid) – Medical, dental, and behavioral health coverage without copays or premiums	**This group may be eligible to purchase insurance through the exchange with appropriate subsidies, or gain coverage through the Basic Health Program (if Connecticut elects that option), or remain on Medicaid (if Connecticut continues to offer coverage through HUSKY A to this group, which is unlikely)**
Pregnant women	Under 133% of FPL[40]	HUSKY A (Medicaid) – Medical, dental, and behavioral health coverage without copays or premiums	**Medicaid (through HUSKY A or HUSKY D) – Medical, dental, and behavioral health coverage without copays or premiums[41]**
	Between 133%-200% of FPL	HUSKY A (Medicaid) – Medical, dental, and behavioral health coverage without copays or premiums	**This group may be eligible to purchase insurance through the exchange with appropriate subsidies, or gain coverage through the Basic Health Program (if Connecticut elects that option), or remain on Medicaid (if Connecticut continues to offer coverage through HUSKY A to this group)**
	Between 200%-250% of FPL	HUSKY A (Medicaid) – Medical, dental, and behavioral health coverage without copays or premiums	**This group may be eligible to purchase insurance through the exchange with appropriate subsidies, or remain on Medicaid (if Connecticut continues to offer coverage through HUSKY A to this group)**
Pregnant women who are undocumented	Under 250% of FPL	Emergency Medicaid – Covers only hospital costs for labor and delivery	Emergency Medicaid – Covers only hospital costs for labor and delivery

Other Immigrants

Populations listed below include naturalized US citizens, legal permanent residents (LPRs), and special categories of immigrants including refugees and asylees but NOT undocumented immigrants unless noted. Bolding indicates new coverage options as a result of federal health reform

Population	Income Requirement	Coverage Options – 2011 *Cost-sharing information is current as of October 2011, but is subject to change prior to 2014*	Coverage Options – 2014 *Cost-sharing information listed is October 2011 coverage for that program, but levels may change significantly by 2014. Only preventive services are guaranteed to remain exempt from cost-sharing*
Adults ages 19-64 (including LPRs only if they have been US residents for over 5 years)	Under 56-68% of FPL[42]	Medicaid-LIA – Medical, dental, and behavioral health coverage without copays or premiums	HUSKY D (Medicaid-LIA) – Medical, dental, and behavioral health coverage without copays or premiums
	Between 56% and 133% of FPL	Charter Oak Health Plan –$446 monthly premium, co-pays, and income-based deductibles and co-insurance[43]	**HUSKY D (Medicaid-LIA) – Medical, dental, and behavioral health coverage without copays or premiums**
Persons with pre-existing conditions who have been without health insurance for at least 6 months[44]	none	**Connecticut Pre-existing Condition Insurance Program – premium of $381/month and copays**	**Purchase health insurance through state exchange (possibly with government subsidy if income-eligible), participate in the Basic Health Program (if offered) or obtain private coverage through an employer (all health plans will be required to cover pre-existing conditions)[45]**
Adults ages 19-64 without insurance	Must not qualify for LIA or CPIP	Charter Oak Health Plan –$446 monthly premium, co-pays, and income-based deductibles and co-insurance	**Purchase individual or small employer coverage on exchanges (with government subsidy if under 400% of FPL)**
Undocumented persons or LPRs who have not met the 5 year residency requirement	Income levels below thresholds for applicable Medicaid category	Emergency Medicaid – covers only treatment required after a medical emergency, including labor and delivery	Emergency Medicaid – covers only treatment required after a medical emergency, including labor and delivery
Refugees, asylees, and other special categories of immigrants if ineligible to receive benefits through other programs[46]	Under 56-68% of FPL	Refugee Medical Assistance - 8 months of Medicaid fee-for-service coverage beginning with month of entry	Refugee Medical Assistance - 8 months of Medicaid fee-for-service coverage beginning with month of entry

[1] The data comes from a CT Voices analysis of American Community Survey data on legal immigrants and estimates of undocumented immigrants from the Pew Hispanic Center using Current Population Survey data. *For more information about how the figures for undocumented immigrants were calculated, see* "Unauthorized Immigrant Population: National and State Trends, 2010," *Pew Hispanic Center* (February 1, 2011) (available at http://pewhispanic.org/files/reports/133.pdf). The US Census considers Puerto Ricans to be native-born citizens born outside the United States (the same designation it applies to persons born on US military bases or to American parents abroad). This brief does not consider Puerto Ricans to be immigrants and therefore does not specifically address issues they face in obtaining insurance and health care. However, many of the topics covered in the brief are relevant to health care access for Puerto Ricans, including language barriers and poverty.

[2] Immigrants in the following categories are eligible to participate in state and federal health care programs and are not subject to the 5 year residency requirement: refugees, asylees, Cuban/Haitian entrants (including Cuban parolees), admitted Amerasian immigrants from Vietnam, victims of human trafficking, unaccompanied alien children, survivors of torture, and Iraqi or Afghan special immigrants. *See* "Who We Serve," *Office of Refugee Resettlement, Administration for Children and Families, US Department of Health and Human Services,* (September 18, 2008), available at: http://www.acf.hhs.gov/programs/orr/about/whoweserve.htm

[3] *See* Karyn Schwartz and Samantha Artiga, "Health Insurance Coverage and Access to Care for Low-Income Non-Citizen Adults," *The Henry J. Kaiser Family Foundation* (June 2007), 3 (available at http://www.kff.org/uninsured/upload/7651.pdf)

[4] *See* William Weir, "Noncitizens Struggle After Losing Health Benefits," *The Hartford* Courant (September 1, 2011) (available at courant.com/health/connecticut/hc-health-care-for-noncitizens-0902-20110901,0,2488984.story)

[5] *See* Pham v. Michael P. Starkowski. 300 Conn. 412, 16 A.3d 635 (2011)

[6] *See* Cindy Mann, memo, "Medicaid and CHIP Coverage of 'Lawfully Residing' Children and Pregnant Women," *Centers for Medicare and Medicaid Services, US Department of Health and Human Services* (July 1, 2010) (available at https://www.cms.gov/smdl/downloads/SHO10006.pdf)

[7] The sponsor deeming requirement counts a portion of the immigrant's sponsor's income as if it were a part of the immigrant's income, even if the individual applying for coverage has no access to those funds. This increases the reported income for the applicant, making ineligible some who would otherwise be income-eligible. *See* "Expanding Coverage for Recent Immigrants: CHIPRA Gives States New Options," *Families USA* (August 2010) (available at http://familiesusa2.org/assets/pdfs/chipra/immigrant-coverage.pdf), 2.

[8] States can receive the higher of CHIP and Medicaid reimbursement levels for children in this option (though they revert to Medicaid funding levels after the children have met the 5 year residency requirement), and receive the Medicaid reimbursement rate for pregnant women. *See* "Medicaid and CHIP Coverage of 'Lawfully Residing' Children and Pregnant Women."

[9] The income eligibility limit is 56% of the FPL for single adults and married couples, but there is an additional 12% deduction for those who live in Region A (mostly southwestern CT) that creates an effective income limit of 68%. *See the list of towns by region in* "In Brief: Connecticut's new Medicaid for Low-Income Adults." *Connecticut Department of Social Services* (June 30 2010) (available at http://www.ct.gov/dss/lib/dss/pdfs/brochures/medicaid_lia_in_brief.pdf)

[10] *See* Michael Starkowski, Provider Bulletin, "National Health Reform - State Administered General Assistance Program Becomes Medicaid for Low Income Adults," *Connecticut Department of Social Services* (June 2010) (available at http://www.ct.gov/dss/lib/dss/pdfs/dss_provider_bulletin_all_providers_saga_to_medicaid_6_10.pdf)

[11] *See* "Connecticut's new Medicaid for Low-Income Adults"

[12] *See* "National Health Reform - State Administered General Assistance Program Becomes Medicaid for Low Income Adults"

[13] *See* Table 1 of "Medicaid Coverage and Spending in Health Reform: National and State-by-State Results for Adults at or Below 133% FPL," *Kaiser Commission on Medicaid and the Uninsured* (May 26, 2010) (available at: http://www.kff.org/healthreform/upload/Medicaid-Coverage-and-Spending-in-Health-Reform-National-and-State-By-State-Results-for-Adults-at-or-Below-133-FPL.pdf), 10

[14] Individuals qualify for subsidies if their employer does not offer coverage or if the employer coverage is considered insufficient (has an actuarial values of less than 60%) or unaffordable (employee share of coverage in excess of 9.5% of income). *See* "Focus on Health Reform: Summary of New Health Reform Law," *Henry J. Kaiser Family Foundation* (April 15, 2011) (available at: http://www.kff.org/healthreform/upload/8061.pdf)

[15] Businesses with fewer than 25 employees and an average wage of under $50,000 will be able to receive tax credits. *See* "States Are Benefiting from Provisions of the Affordable Care Act," *Families USA* (March 2011) (available at http://familiesusa2.org/assets/pdfs/health-reform/Benefits-of-Health-Care-Law.pdf)

[16] *See* "U.S. Preventive Services Task Force Recommendations," *US Department of Health and Human Services* (updated January 31, 2010) (available at http://www.healthcare.gov/law/resources/regulations/prevention/taskforce.html)

[17] Out of pocket liability will be capped for individuals making under 400 percent of the FPL. Cost-sharing will be reduced for those making under 250 percent of the FPL through a variety of measures such as reduction in co-payments and deductibles. *For more information about cost-sharing and liability limits, see* "Explaining Health Care Reform: Questions About Health Insurance Subsidies," *Henry J. Kaiser Family Foundation* (April 2010)

(available at http://www.kff.org/healthreform/upload/7962-02.pdf)

[18] *See* "Health Insurance Coverage and Access to Care for Low-Income Non-Citizen Adults," 5

[19] The offerings of the Basic Health Program option depend upon pending federal regulations from the US Department of Health and Human Services, guidance from the Connecticut Health Insurance Exchange Board, and future state legislative decisions.

[20] "Implementing SustiNet Following Federal Enactment of the Patient Protection and Affordable Care Act of 2010: A Preliminary Report to the Connecticut General Assembly," *SustiNet Health Partnership Board of Directors* (May 30, 2010) (available at: http://www.ct.gov/sustinet/lib/sustinet/board_of_directors_files/reports/sustinet_60_day_report_05272010.pdf), 15

[21] *See* "The Basic Health Plan — An Emerging Option for States," *Center for U.S. Health System Reform* (March 24, 2011) (available at: http://healthreform.mckinsey.com/en/Insights/Reform_Center_Health_Intelligence/The_Basic_Health_Plan.aspx)

[22] The exchange subsidies for 5 year barred immigrants earning under 133% of the FPL are the same as those offered to people making 133%-200% of the FPL because the subsidies are calibrated assuming everyone under 133% of the FPL is receiving Medicaid-LIA. Immigrants making under 133% of the FPL have a significantly lower ability to pay than the subsidies assume, making exchange coverage quite possibly unaffordable even with the subsidies.

[23] The hardship exemption applies to those with income below the tax filing threshold ($9,350 for individuals and $18,700 for couples in 2009) or for whom the cost of the minimum policy would be greater than 8 percent of their income. *See* "Focus on Health Reform: Summary of New Health Reform Law."

[24] Starting in 2016, the fine will be $695 or 2.5 percent of taxable income, and it will increase by the cost of living adjustment thereafter. *See* "Focus on Health Reform: Summary of New Health Reform Law."

[25] Penalties will be $2000-$3000 per employee receiving a subsidy to purchase exchange coverage. Businesses with fewer than 50 employees are not subject to penalties. *For more information about the employer coverage mandate and penalties, see* "Focus on Health Reform: Summary of New Health Reform Law."

[26] 55 percent of uninsured low-income non-citizen adults reported going without preventive care, compared to 15 percent of those with insurance. These disparities also appear in the rates of those going 2 or more years without contact with a health professional (44% for those without insurance versus 16% for those with insurance) and those lacking a usual source of care (65% versus 16%). *See* "Health Insurance Coverage and Access to Care for Low-Income Non-Citizen Adults," 4-5

[27] "Applying for Health Coverage Online: The Affordable Care Act Helps Americans Enroll," *Families USA* (March 2011) (available at: http://familiesusa2.org/assets/pdfs/ApplyingforHealthCoverageOnline.pdf)

[28] Memo to State Health Officials. "Re: Medicaid and CHIP Coverage of "Lawfully Residing" Children and Pregnant Women," *Centers for Medicare and Medicaid Services, US Department of Health and Human Services* (July 1, 2010) (available at: https://www.cms.gov/smdl/downloads/SHO10006.pdf)

[29] Donna Cohen Ross, "New Citizenship Documentation Option for Medicaid and Chip Is Up and Running," *Center for Budget and Policy Priorities* (April 20, 2010) (available at: http://www.cbpp.org/cms/index.cfm?fa=view&id=3159)

[30] *For more information about the SAVE program, see* "Information for Noncitizens Applying for a Public Benefit," *U.S. Citizenship and Immigration Services* (August 19, 2011) (available at: http://www.uscis.gov/portal/site/uscis/menuitem.eb1d4c2a3e5b9ac89243c6a7543f6d1a/?vgnextoid=64d2feb9a2ca8210VgnVCM100000082ca60aRCRD&vgnextchannel=64d2feb9a2ca8210VgnVCM100000082ca60aRCRD)

[31] "Presumptive Eligibility for Children," 42 U.S.C., 1396R-1A (b)(3)

[32] *See* "Health Insurance Coverage and Access to Care for Low-Income Non-Citizen Adults," 4 and "Community Health Centers and the Affordable Care Act: Increasing Access to Affordable, Cost Effective, High Quality Care," *US Department of Health and Human Services* (September 11, 2011) (available at: http://www.healthcare.gov/news/factsheets/2010/08/increasing-access.html)

[33] Christine Bahls, "Health Policy Brief: Achieving Equity in Health," *Health Affairs* and *The Robert Wood Johnson Foundation,* (October 6, 2011), 5 (available at http://www.rwjf.org/files/research/72893.disparities.pdf)

[34] "Immigrants' Health Coverage and Health Reform: Key Questions and Answers," *Henry J. Kaiser Family Foundation* (December 2009) (available at: http://www.kff.org/healthreform/upload/7982.pdf)

[35] *See* "Benefit Package," *Connecticut Department of Social Services* (March 11, 2011) (available at http://www.huskyhealth.com/hh/cwp/view.asp?a=3573&q=421554&hhNav=)

[36] *See* "Benefit Package"

[37] *See* "Benefit Package"

[38] Connecticut is renaming its plans to include HUSKY C (Medicaid for the Aged, Blind, and Disabled) and HUSKY D (Medicaid-LIA).

[39] HUSKY A and Medicaid-LIA (soon to be HUSKY D) currently offer the same benefits without cost-sharing. There is, however, the potential for changes to coverage or cost-sharing under any of the options available in 2014.

[40] *See* "Benefit Package"

[41] *See note at 35.*

[42] *See,* "In Brief: Connecticut's new Medicaid for Low-Income Adults."

[43] *See* "Charter Oak Fact Sheet" *Connecticut Department of Social Services* (July 2011), available at http://www.charteroakhealthplan.com/coh/lib/coh/pdf/charter_oak_fact_sheet_july_2011.pdf

[44] *See* "Connecticut Pre-Existing Condition Insurance Plan," *Connecticut Department of Social Services* (September 28, 2011),

available at http://www.ct.gov/dss/cwp/view.asp?Q=463668&A=2345

[45] While no statutory changes have yet been made, nor has an official statement been released, it is widely expected that the Charter Oak Health Plan will be phased out after the exchanges become operational.

[46] Persons are eligible for RMA if they fit into the following categories: refugees, asylees, Cuban/Haitian entrants (including Cuban parolees), admitted Amerasian immigrants from Vietnam, victims of human trafficking, unaccompanied alien children, survivors of torture, and Iraqi or Afghan special immigrants. *See* "Who We Serve," *Office of Refugee Resettlement, Administration for Children and Families, US Department of Health and Human Services,* (September 18, 2008), available at: http://www.acf.hhs.gov/programs/orr/about/whoweserve.htm