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Leighton C. Ku
George Washington University

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Issue Brief

By

Leighton Ku, PhD, MPH
Professor of Health Policy
Director, Center for Health Policy Research

The George Washington University
School of Public Health and Health Services
Department of Health Policy

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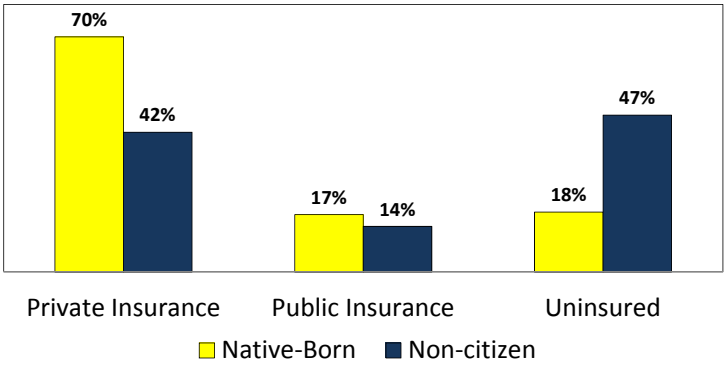
During the first half of 2013, there was tremendous momentum to pass legislation to repair the nation's dysfunctional immigration system. After months of bipartisan wrangling, the Senate voted 68-32 in late June to pass a comprehensive immigration reform bill, the Border Security, Economic Opportunity, and Immigration Modernization Act (S. 744).[1] However, momentum has stalled: Speaker John Boehner has said the House of Representatives would not allow a vote on the Senate bill and would develop an approach more consistent with House Republican views. As every day passes it seems less likely that a new immigration law will be passed this year, given other high-profile items on Congress's agenda and the short remaining session.

This brief summarizes key opportunities helping the nation's newcomers in gaining health insurance coverage and health access that are possible under the current law. Provisions of the Affordable Care Act (ACA) will help millions of legal immigrants gain access to affordable health insurance coverage. At the same time, however, immigrants will also face new responsibilities. Like citizens, lawfully present immigrants will be responsible for having health insurance coverage or paying a tax penalty, although some are exempt. Rules about immigrants' access to health insurance benefits are often complicated because they depend on specific immigration categories, as well as eligibility for other insurance programs. Federal policies are summarized on page 2, with more explanation in the paper.

Opportunities Under the Affordable Care Act

Private Insurance and Health Insurance Marketplaces. The largest gaps in immigrants' health insurance coverage are related to disparities in private health insurance coverage. As seen in Figure 1, 70% of native-born adults have private health insurance coverage, compared to only 42% of non-citizen immigrants. As a result, non-citizen adults are about three times as likely to be uninsured (47%) as the native-born (18%).

Figure 1.
Health Insurance Coverage of Native-born and Non-citizen Non-elderly Adults in 2012



Source: GW analysis of March 2013 Current Population Survey
Note: Levels do not sum to 100% because of overlap in private and public insurance. Data for naturalized citizens are not shown.

[1] Under the Senate bill, unauthorized immigrants who attain provisional legal status would be barred from health insurance assistance for a protracted period. See Ku L. "The Bipartisan Senate Immigration Bill: Implications for Health Coverage and Health Access," GW Department of Health Policy Issue Brief, Aug. 8, 2013. Available at: http://sphhs.gwu.edu/departments/healthpolicy/publications/ImmigrationReform.pdf

Table 1. Summary of Eligibility for Federal Health Insurance Assistance by Immigration Status

Program Eligibility	Native-born or Naturalized Citizens	"Qualified" Lawful Immigrants (1)	Other Lawfully Present or Lawfully Residing (2)	Unauthorized
Health Insurance Marketplace (at full price) (3)	Eligible	Eligible	Eligible	Not eligible
Individual Premium Assistance Tax Credits for Use in Marketplaces (3)	Eligible 100%-400% of poverty	Eligible 100%-400% of poverty. Also under 100% if not eligible for Medicaid.	Eligible 100%-400% of poverty. Also under 100% if not eligible for Medicaid.	Not eligible
Medicare (4)	Eligible	Eligible	Eligible	Not eligible
Medicaid or CHIP (5)	Eligible	Eligible if in U.S. for more than 5 years with some exceptions. State option: children and pregnant women without 5 year wait.	State option: Children or pregnant women may be eligible. Otherwise only eligible for emergency Medicaid	Emergency Medicaid only. Prenatal care available If state uses CHIP unborn child option.
Basic Health Program Option (6)	Eligible	Eligible. May also be eligible with incomes below 100% of poverty if not eligible for Medicaid	Eligible. May also be eligible with incomes below 100% of poverty if not eligible for Medicaid	Not eligible

Notes:

1. Includes lawful permanent residents (LPRs), refugees, asylees and certain other groups.
2. Includes legal immigrants not classified as 'qualified' lawful immigrants, including visa holders, those with temporary protected status and certain other categories. The Deferred Action for Childhood Arrivals category is excluded.
3. Eligibility for the marketplace and tax credits is limited to those who are not otherwise eligible for affordable insurance or who enroll through a small business. The tax credits are available only to those buying insurance individually or for their families, not through the small business component.
4. A principal eligibility criterion for premium-free Medicare is Social Security eligibility and having earned 10 years or more of Social Security eligible employment. Some elderly citizens and many lawful immigrants may not qualify because of these criteria, although there are options to "buy into" Medicare for LPRs who have been in the U.S. over 5 years.
5. Enrollees must also meet income and category-related Medicaid and CHIP eligibility criteria, which vary by state. Under the ACA, about half the states are expanding eligibility for non-elderly adults up to 138% of poverty.
6. Basic Health is an ACA option primarily for persons with incomes between 138% and 200% of poverty. Final regulations have not been issued and it is not clear which states will adopt this option in the future.

Some immigrants may be eligible for state or local assistance without federal funding, at the option of those jurisdictions.

Immigrants frequently work in jobs that do not offer employer-sponsored insurance, such as construction, food service, agriculture, personal service or temporary/seasonal jobs. In addition, since they often hold low-wage jobs, they may not be able to afford premiums even if their employer offers insurance or be able to afford non-group insurance policies. While there are differences in public insurance coverage of adults too, the gaps in private insurance coverage are what drive the overall disparities in insurance coverage of immigrants. The lack of private insurance coverage for adult immigrants also has repercussions for the coverage of their children, whether the children are U.S.- or foreign-born. Problems with parents' insurance coverage can reduce their children's insurance coverage too.

Individual and Family Coverage Through the Health Insurance Marketplaces. The new health insurance marketplaces (also called exchanges) and related premium assistance tax credits that will begin on January 1, 2014 offer important new opportunities for many immigrants to gain access to affordable private insurance. Under the Affordable Care Act "*lawfully present*" non-citizen immigrants will be able purchase private insurance at the marketplaces, although unauthorized immigrants are ineligible. In addition, the law offers premium assistance tax credits to help them afford coverage in the marketplaces if they are not otherwise eligible for insurance (e.g., are not offered employer-sponsored insurance or are not eligible for Medicaid, CHIP or Medicare) and have incomes below 400% of the federal poverty line. Lawfully present immigrants include not only immigrants who are lawful permanent residents (green card holders), but also those in other immigration categories, such as immigrants with work visas, temporary protected status and many others.[2]

The total number of lawfully present immigrants who are not otherwise eligible for Medicaid and who may therefore be able to purchase insurance on the health insurance marketplaces is difficult to determine, but it is at least several million. Statistics from the Department of Homeland Security indicate that there were about 4 million lawful permanent residents who have been present for less than five years[3] (and are generally ineligible for Medicaid under federal rules) and about 1.9 million "non-immigrant" residents (e.g., those with work or student visas who are lawfully admitted to the U.S. for a temporary period), in 2011.[4] Thus, a conservative estimate of the number who could potentially be helped is about 6 million people.

For most people, eligibility for premium assistance tax credits is limited to those with incomes between 100 and 400% of poverty. But the ACA also lets lawfully present immigrants with incomes below 100% of the poverty line receive the tax credits if they are not eligible for Medicaid.[5] When enacting the ACA, Congress recognized that some low-income lawfully present immigrants are not eligible for Medicaid, such as most lawful permanent residents in the U.S. for less than five years as well as those in other legal immigration categories, such as those with work visas, and may therefore lack access to affordable health insurance. Thus, it specifically offered these low-income lawfully present immigrants access to the health insurance marketplaces and federal tax credits. (A warning: because this exemption is not well known, lawfully present immigrants with incomes below poverty may face problems applying for marketplace coverage and tax credits and may need special assistance getting health coverage.)

Since the ACA was enacted, the Supreme Court ruled that ACA Medicaid expansions are optional for states. As of early October 2013, about half the states have opted to not expand

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[2] A more complete list of categories considered "lawfully present" can be found in HHS regulations at 45 CFR 152.2. However, young people granted temporary legal status under the Deferred Action for Childhood Arrivals (DACA) policies are not eligible for the health insurance marketplaces or tax credits. Also see National Immigration Law Center, "Lawfully Present Individuals Eligible under the Affordable Care Act," Sept. 2012. Available at http://www.nilc.org/ACAfacts.html

[3] Rytina N. "Population Estimate: Estimates of the Legal Permanent Resident Population in 2012." Office of Immigration Statistics, Department of Homeland Security, July 2013.

[4] Baker B. "Estimates of the Size and Characteristics of the Resident Nonimmigrant Population in the United States: January 2011" Office of Immigration Statistics, Department of Homeland Security, Sept. 2012.

[5] See Internal Revenue Service regulations at 26 CFR 136-2(b)(5) – (b)(7).

Medicaid.[6] Although these states are not expanding Medicaid, low-income lawfully present immigrants in those states may be eligible for the health insurance marketplaces and federal tax credits. All lawfully present immigrants may be able to purchase insurance from the health marketplaces and get tax credits if they have incomes below 400% of poverty and are not eligible for other insurance, including Medicaid. (In those states, qualified[7] immigrants who have been in the U.S. for more than five years and who meet the state's Medicaid income and category standards would be eligible for Medicaid instead of the health marketplaces.)

While the health insurance marketplaces offer comprehensive private health insurance, the benefits will not be quite as broad as in Medicaid (e.g., there is no long term care coverage). More important, while Medicaid generally does not charge premiums and has modest copayments, participants in the marketplaces will need to pay premiums and other cost-sharing (e.g., deductibles or copayments). Those with household incomes below 133% of poverty would pay 2% of their household income for premium of a "benchmark" plan, the second lowest silver metal tier plan. Those with higher incomes will pay a gradually increasing share of premium cost.[8]

In states that expand Medicaid, lawfully present immigrants who are not eligible for Medicaid may also participate in the marketplaces. In those states, many low-income immigrants will be eligible for Medicaid if they are "qualified" immigrants, as defined under the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (welfare reform) and have had a "qualified" status for at least five years (or meet another state eligibility criterion). Other low-income lawfully present immigrants (e.g., those in a qualified status for less than five years or visa holders) are not Medicaid-eligible and will instead qualify for the health insurance marketplaces and federal tax credits.

Like the native-born, immigrants are sensitive to the cost of health insurance premiums. For example, a recent study of Mexican immigrants in Los Angeles found that 47% would be willing to pay for binational health insurance if it cost $50 per month per person but only 18% would be willing to pay $100 per month.[9] On the other hand, as described below, the individual

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[6] Centers for Medicare and Medicaid Services. "State Medicaid and CHIP Income Eligibility Standards Effective January 1, 2014", issued Sept. 30, 2013.

[7] See the Medicaid section for a discussion of "qualified" immigrants. The term can be a little confusing because a person meet the criteria for a qualified immigrant, but still not be eligible for Medicaid because he or she has been in the U.S. for under five years.

[8] In the health insurance exchanges, there are four "metal tiers" that have a range of insurance coverage. For a "bronze" level plan, the insurer is expected to cover about 60% of total medical costs, while the consumer pays 40% in the form of deductibles, coinsurance and copayments. The insurer covers about 70% of total medical costs for "silver" plan, 80% for a "gold" plan and 90% for a platinum plan and the consumer pays the balance. Since bronze plans offer less insurance protection, they have lower monthly premiums, but out-of-pocket costs will be higher. Under the ACA, the second lowest cost "silver" plan in an area determines the benchmark that is used to determine the level of federal tax credits. The amount of the federal tax credit is related to an applicant's household income. Those with incomes below 133% of poverty only have to pay 2% of income for the benchmark plan. As income rises, the percentage the individual pays gradually rises up to 4% at 150% of poverty and eventually reaching 9.5% of income for those with incomes between 300% and 400% of poverty. Above 400% of poverty, there are no premium subsidies.

[9] Block M, Bustamante A, de la Sierra L and Cardoso A. "Redressing the Limitations of the Affordable Care Act for Mexican Immigrants Through Bi-National Health Insurance: A Willingness to Pay Study in Los Angeles." *J Imm Minor Hlth*, Sept 2012. DOI 10.1007/s10903-012-9712-5

responsibility requirement to have insurance coverage also applies to lawfully present immigrants, so uptake should be higher.

Example of Premium Assistance Tax Credits in Health Marketplaces for Lawfully Present Immigrants

In a state with no Medicaid expansion, suppose a single lawfully present immigrant whose income is 75% of the poverty line ($8,618 per year, working about 3 days a week at minimum wage) applies for coverage in the state's health insurance marketplace. Although he is below the standard 100% of poverty threshold for eligibility for tax credits in the marketplace, he qualifies because he is a lawfully present immigrant not eligible for Medicaid under the rules that apply in his state.

For a "benchmark plan" – the second lowest cost silver plan – the amount he would have to pay for coverage is 2% of his income: $172 per year or about $14 per month. Suppose the full premium (before subsidies) for that plan is $250 per month. (The full premium depends on the plan selected, his age and smoking status). His federal tax credit would equal $236 per month ($250 minus $14). That credit would be subtracted from the actual cost of insurance he selects.

- If he selects the benchmark – the second lowest cost silver plan-- he would pay $14 per month for insurance.
- If he chooses a lower cost plan that has a premium of $240 per month, since his federal tax credit is $236 per month, he would pay $4 per month ($240-$236).
- If he selects a more generous plan with a $300 monthly premium, he would pay $64 per month ($300-$236.)

Selecting a silver plan would also make him eligible for cost-sharing reductions to lower out-of-pocket costs for medical visits or medications. Under the ACA, maximum out-of-pocket costs for those between 100% and 200% of poverty must be reduced by at least two-thirds. In addition, for those between 150% and 200% of poverty, the plan must cover at least 94% of the expected costs. Under the ACA rules, those whose incomes are below the poverty line are treated as if their incomes are 100% of poverty.

All those who apply for the marketplaces and for tax credit assistance, citizens and immigrants alike, must demonstrate that they are lawfully present in the U.S. under HHS rules. In order to apply, they will need to provide Social Security numbers for themselves and other family members who are applying for help.[10] This information will be checked against Social Security Administration and/or Department of Homeland Security data bases. Immigrants should only use SSNs that have been issued to them by the Social Security Administration. For various reasons, some lawfully present immigrants may face delays in having their status verified electronically, or may need the agency to check their records manally. If they have presented their immigration documents, and are otherwise eligible for coverage, the Marketplace agency should provide access to coverage while this verification process proceeds. However, it is

[10] Social Security numbers must only be provided for those applying for insurance coverage and the principal taxpayer in the household, if they have one. Certain lawfully present immigrants may not be eligible for, or may not have, SSNs. An individual not applying for herself (such as an undocumented parent applying for her citizen child) should have the opportunity to indicate she is not an applicant, should not be asked for her citizenship or immigration status, and cannot be required to provide a Social Security number if she does not have one.

important to note that immigration information will only be used to determine eligibility for health insurance. The Department of Homeland Security has confirmed that any immigration information collected in this process is solely for the determination of insurance eligibility and will not be used in immigration enforcement actions.[11]

Insurance Coverage for Small Business Employees Through the Marketplaces. Immigrants may also participate in the health insurance marketplaces if they work for a small business (less than 50 workers, later phasing up to 100 workers) that is buying health insurance through the SHOP marketplaces (Small Business Health Insurance Options Program). Historically, small businesses have had difficulty getting affordable health insurance premiums; the SHOP marketplaces will offer competitive pricing for a large variety of health plans. In addition, small businesses that buy insurance through SHOP may be eligible for federal tax credits too that help the firms afford coverage.

Individuals who get coverage through the SHOP exchanges will not get federal premium assistance tax credits; instead their employers will cover a portion of the premiums, reducing the amount that workers or their families need to pay. The process for SHOP enrollment does not include a review of citizenship or immigration status information, given employers' responsibility for determining that they could work legally. But both the small employer and the workers will need to provide Tax Identification Numbers, usually Social Security numbers.

As noted earlier, one of the primary reasons that immigrants lack insurance is the difficulty they face getting private health insurance. The ACA can help fill this gap by offering competitive prices for health insurance premiums in the marketplaces and federal tax credits for those who would otherwise be unable to get insurance. It will help more lawfully present immigrants get private insurance for themselves and their families.

Outreach and Assistance. The health insurance marketplaces have been designed as online internet-based systems. Recognizing that many individuals and small businesses may have difficulty navigating the online systems or understanding their insurance choices, health reform provides "navigators", "in-person assisters," insurance brokers and others who can offer personal one-on-one assistance in enrollment and selection of insurance plans. These services are to be provided in appropriate languages for the needs of potential enrollees, particularly Spanish which is the most common language in the U.S. other than English.[12] In most areas, grants for navigation services have included targeting to organizations that are prepared to offer linguistically and culturally appropriate services. The navigators or assisters can individually assist immigrant applicants, helping to answer their questions and working with them to complete the applications, even translating questions and answers.

Individual Responsibility to Have Health Insurance. Finally, it is important to note that the ACA requirement that individuals must either have health insurance coverage or pay a tax penalty – the so-called "individual mandate" – applies to all lawfully present immigrants, just as it applies to citizens and the native-born. In 2014, the penalty for lacking insurance coverage is $95 or one percent of income, whichever is more; the penalty rises in subsequent years.

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[11] Office of the Director, U.S. Immigration and Customs Enforcement, Department of Homeland Security. "Clarification of Existing Practices Related to Certain Health Care Information." Oct. 25, 2013.

[12] Sec. 1311(h)(3)(E) of the ACA. Insurers are required describe their plans' policies in "plain language," including accommodation for those with limited English (Sec. 1311(e)(3)(B)).

For both citizens and immigrants alike, there are exemptions for those with incomes are below the federal income tax threshold (around $10,000 for an individual[13]) or if insurance premiums would be too expensive compared to their income. Immigrants who are not "lawfully present" (primarily unauthorized immigrants) are exempt from this requirement. The ACA not only includes assistance to help lawfully present immigrants get health insurance coverage, it can penalize those who fail to get coverage.

Medicaid and CHIP Expansions. As originally enacted, the ACA would have expanded Medicaid eligibility for non-elderly adults with incomes up to 133% of the poverty line. The Supreme Court's June 2012 decision modified that so that states now have the option whether to expand Medicaid. As of early October 2013, about half the states, including some such as California, New York, Illinois and Arizona with large immigrant populations, are expanding Medicaid eligibility for adults to 133% of the poverty line (or 138% if the 5% standard deduction is included). As a result, more legal immigrants, including childless adults and low-income parents, will be eligible for Medicaid coverage. But other states, like Texas and Florida, are not expanding Medicaid at this time.

The ACA did not change the basic rules about immigrants' eligibility for Medicaid or the Children's Health Insurance Program (CHIP). As a brief recap, certain legal immigrants (primarily lawful permanent residents who have been in a qualified status for five or more years and refugees or asylees) are eligible for Medicaid, provided that they also meet regular income and categorical standards.[14] Roughly 4 million lawful permanent residents have been present for less than five years and are therefore ineligible for Medicaid.[15] (An exception is that other lawfully present and unauthorized immigrants may be eligible for Medicaid coverage of emergency medical care; but they are not eligible for full Medicaid coverage.)

In addition, there is a state option to extend Medicaid or CHIP eligibility to children under 21 and pregnant women who are "lawfully residing" in the United States. About half of the states have adopted the option for children or pregnant women.[16] Finally, a number of states provide state-funded health insurance coverage to legal immigrants (and sometimes the unauthorized) who cannot be covered with federal Medicaid or CHIP funds.

The fact that about half the states are expanding Medicaid and that almost half have adopted state options for legal immigrant children and pregnant women also means that about half the states still have the opportunity to expand Medicaid and more than half have the opportunity to adopt the child and pregnant woman option. Because of the Supreme Court decision, states can decide to adopt an expansion at any time, although there is a stronger

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[13] For 2013, the federal income tax threshold for an individual is $10,000: $6,100 for the standard deduction plus $3,900 for the personal exemption for one person; people with incomes below that level would not owe any federal income taxes and are not required to file tax returns. The threshold is higher for couples and larger households and varies depending on tax filing status and household size.

[14] For a more detailed explanation, see National Immigration Law Center, *Guide to Immigrant Eligibility for Federal Benefits*, 4th Edition, 2002 and updates, available at http://www.nilc.org/guidefed.html. Or see Office of the Assistant Secretary for Planning and Evaluation, HHS, "Summary of Immigrant Eligibility Restrictions Under Current Law, As of 2/25/2009," available at http://aspe.hhs.gov/hsp/immigration/restrictions-sum.shtml.

[15] Rytina N., *op cit.*

[16] This is authorized by Sec. 214 of the CHIP Reauthorization Act of 2009. Sometimes it is called the ICHIA option, after the Immigrant Children's Health Improvement Act proposal, on which it was based.

financial incentive to expand sooner since the federal government will cover 100% of the costs for the newly eligible in 2014, 2015 and 2016 and the matching rate then gradually declines to 90%. States that expand Medicaid eligibility for legal immigrant children or pregnant women can use their CHIP funds to support this and use the CHIP matching rate, which provides a higher percent of federal matching funds than the standard Medicaid rate (at least 65%)..

Another option is available under CHIP, the so-called "unborn child" option. States may use their CHIP funds to provide coverage to unborn children, which essentially means that the pregnant woman may gain coverage for prenatal care. Since all children born in the U.S. are native-born citizens, this also means that their mothers may receive prenatal coverage, regardless of her immigration status. From the perspective of the regulation, this is health insurance for the unborn child, not the mother. While there are alternative methods to expand coverage for pregnant women in Medicaid, this is the only option that could be used to help unauthorized women with federal matching funds.

Basic Health Program Option. The ACA also created a final option that could help immigrants and other lower income consumers: the Basic Health Program (BHP) option.[17] States may adopt this option to provide insurance coverage for certain low-income people as an alternative to coverage through the health insurance marketplaces. If established, BHPs must provide health insurance coverage with at least the same benefits as offered in the marketplaces and would feature lower premiums and cost-sharing as marketplace plans. In order to defray the costs for BHPs, the federal government will pay states 95% of the premium tax credit and costs-sharing reduction that each beneficiary would have earned in the marketplace instead. In principle, a BHP would offer benefits that are equal or better than marketplace benefits with lower premiums and cost-sharing that are available from marketplace plans. In late September, HHS released a notice of proposed rulemaking for BHP,[18]and states will not be able to implement BHP without HHS approval which would need to wait until final regulations are issued. It is generally believed that BHP programs could not be operational until FY 2015.

In general, to be eligible for a state BHP, a person must be ineligible for full Medicaid benefits or other health insurance (e.g., employer-sponsored coverage) and must have an income between 133% and 200% of poverty. In addition, lawfully present non-citizens who are ineligible for Medicaid because of their immigration status can even be eligible if they have incomes below 133% of poverty. Thus, BHPs could provide health insurance coverage for lawfully present immigrants if they are low-income and not eligible for Medicaid, even if the state has not expanded its Medicaid program or if the immigrants have been in the U.S. for less than five years.

It is not yet clear which states will adopt the BHP option. While a number of states expressed interest earlier the delay in federal guidance and lack of final regulations may deter interest.

Other Federal Assistance. The other two mainstays of federal assistance for health insurance are Medicare and federal income tax deductions and credits.

[17] Sec. 1331 of the ACA.
[18] *Federal Register*, 78(186): 59122-51, Sept. 25, 2013. 45 CFR Part 144

Medicare. Unauthorized immigrants are not eligible for Medicare. Lawfully present immigrants with sufficient work history may be eligible for "premium-free" Medicare. The Medicare requirement -- that people must have a sufficient work history in Social Security related employment (10 years or more on their own or through a spouse) to qualify for "premium free" Part A hospital coverage -- presents a stumbling block for many immigrant seniors, as well as some citizens without a sufficient work history. However, citizens, or lawful permanent residents who have resided continuously in the U.S. for five years, can buy into Medicare if they do not have sufficient years of work. Parts B and C coverage (physician and prescription drug coverage) are typically financed through deductions from Social Security payments, but people may pay directly.

It is worth noting that since unauthorized immigrants pay Medicare and Social Security payroll taxes when they are employed, but do not receive Social Security or Medicare benefits, they contribute to surpluses in the Medicare and Social Security Trust Funds and help protect the funds' solvency.[19]

Federal Income Tax Deductions or Credits. Finally, most Americans who have private health insurance receive federal financial assistance in the form of federal (and often state) income tax deductions or credits. This tax assistance is offered without regard to immigration status. The largest type of aid is the deductions offered to employers for the cost of health insurance premiums as an employee benefit, which makes employer-sponsored insurance more affordable. But other tax assistance, such as tax deductions for the self-employed or for Health Savings Accounts, are available for individual taxpayers, and do not include immigration-related restrictions.

Other Options and Challenges

The new insurance opportunities that are available under the ACA can only work if immigrants know about them and feel comfortable with these approaches. The ACA includes provisions for linguistically-appropriate outreach and education and for the use of in-person navigators and assisters to help people understand how to enroll in the new marketplaces or exchanges. It will also be important to reach out to small businesses that employ a substantial share of immigrant workers. However, efforts may differ from area to area; some states are supporting the ACA expansions and making resources available, while others have been more resistant to health reform implementation.

Care in the Health Care Safety Net. Uninsured immigrants often obtain care from safety net health care providers, such as community health centers, free clinics, public and nonprofit hospitals as well as other more specialized providers like family planning or HIV clinics or mental health agencies. In particular, many nonprofit or public agencies offer free or reduced price prenatal care for uninsured women, including unauthorized immigrants, because of the value of prenatal care. Many private clinicians are also willing to offer free or reduced care for uninsured patients on a voluntary basis. These safety net providers are likely to continue to be important sources of health care for uninsured people, including immigrants, in the future.

[19] Zallman L, et al. Immigrants Contributed An Estimated $115.2 Billion More To The Medicare Trust Fund Than They Took Out In 2002–09. *Health Affairs.* 32(6): 1153-60. Goss, S., Chief Actuary of the Social Security Administration. Letter to Senator Marco Rubio, March 8, 2013.

There could be access problems, however, because the supply of free or reduced price care may be limited in a given area. The ACA provided additional funding for community health centers in 2014 and 2015, so there ought to be an increase in their capacity, although funding for future years is uncertain. However, special Medicaid payments to safety net hospitals – disproportionate share hospital payments – are gradually being reduced, which might limit their capacity. To the extent that safety net providers are able to collect more revenue from insured patients and have less uncompensated care, they may be able to continue to provide safety net services to uninsured patients, including immigrants. As noted earlier, low-income uninsured immigrants may be able to get Medicaid coverage for emergency room care, too, although they would not be covered for non-emergency services.[20]

Language Barriers. Immigrants may face a variety of challenges in obtaining health care, even if they have insurance. Some are problems faced by many low-income people, such as affordability, transportation problems, scheduling difficulties, misunderstanding of health problems or confusion about managed care systems.

A problem more specific to immigrants is language barriers. Under federal civil rights law and policy, health care providers are responsible for providing free language assistance to those with limited English proficiency in order to prevent discrimination due to national origin.[21] Nonetheless, language barriers and difficulties finding a clinician who speaks an immigrant's language or a skilled interpreter to help translate are still commonplace.[22] But there has been gradual progress. The Joint Commission and the National Committee for Quality Assurance have established quality standards aimed at improving the availability of language assistance in hospitals; these standards may eventually spread to ambulatory care settings.[23] The Office of Minority Health at HHS recently updated its National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care.[24] The ACA also requires that health-care records include information about patients' primary language, along with more commonly reported items such as gender and race/ethnicity, which should make it easier to plan for adequate language services and to monitor disparities in health-care delivery that could be related to language barriers. Also, as discussed earlier, the ACA includes a variety of provisions to help ensure that there is language assistance to help those with limited English proficiency enroll in the health insurance marketplaces or Medicaid.

Insurers, including the federal and state governments as well as private insurers, could help by establishing policies to reimburse health-care providers for language assistance services, such as interpreters, to patients with limited English proficiency. Medicare does not currently provide reimbursement for language services, nor do most private insurers. If Medicare paid for

[20] Emergency Medicaid coverage can be provided regardless of immigration status, but the person must meet other Medicaid eligibility criteria for that state, including income and categorical standards.

[21] Executive Order 13166, August 11, 2000. "Improving Access to Services for Persons with Limited English Proficiency."

[22] Regenstein M, Andres E, Wynia M. "Appropriate Use of Non–English-Language Skills in Clinical Care." *JAMA*. 2013;309(2):145-146

[23] For example, the National Committee for Quality Assurance (NCQA), *Implementing Multicultural Health Care Standards: Issues and Example* (Washington, DC: NCQA, 2009) and the Joint Commission, *Patient-Centered Communication Standards for Hospitals* (Oakbrook Terrace, IL: Joint Commission, 2010).

[24] Available at https://www.thinkculturalhealth.hhs.gov/Content/clas.asp

language services, it seems likely that many private health insurance plans would follow suit. A number of state Medicaid programs pay for language services, and the 2009 CHIP Reauthorization Act offers matching funds for administrative costs for interpretation and translation services. However, the majority of state Medicaid programs do not cover these services. Thus, health-care providers must pay for these services without reimbursement, reducing their willingness to provide adequate language services.

Conclusions

Immigrants, particularly adults, face significant barriers in obtaining health insurance coverage and access to care in the United States, particularly private health insurance. The ACA provides important new opportunities as well as new responsibilities to help lawfully present immigrants obtain health coverage through the health insurance marketplaces, Medicaid or potentially under Basic Health Programs. The law is particularly significant for the segment of immigrants who did not previously qualify for Medicaid, but who are considered lawfully present. This group includes lawful permanent residents in the U.S. for under five years, visa holders and those with temporary protected status. The level of uninsurance for this segment is not clear, but it is reasonable to believe that more than half are uninsured.[25] This group will generally be eligible for the health insurance marketplaces and federal tax credits. Many other legal immigrants will qualify for Medicaid as about half the states expand Medicaid eligibility. If states implement Basic Health Program options, there may be some additional opportunities.

At the same time, it is equally important to recognize that lawfully present immigrants are subject to the individual responsibility mandate of the ACA, just as citizens are. They must either have private or public health insurance or pay a tax penalty. Some will be exempt because their incomes are too low or because they lack access to affordable health insurance coverage. The combination of opportunities and penalties lead to substantial gains in insurance coverage for a group that historically had had very high levels of uninsurance.

As important as insurance is, it is only part of the equation. Other factors that ultimately affect access to health care are the availability of safety net health providers and the extent to which language assistance is available for those who do not speak English proficiently. These issues will remain important in the coming years.

[25] A recent report estimated that 40% of legal non-citizen adults and 71% of unauthorized adults were uninsured. However, that analysis could not completely differentiate certain categories of lawfully present adults, such as those with visas or temporary protected status and did not differentiate them by years in the United States, so some of the lawfully present group are assigned in the legal noncitizen adults and some with the unauthorized. It is reasonable to infer that the other lawfully present immigrants are between 40% to 71% uninsured and probably more than 50% are uninsured. See Capps R, Bachmeier J, Fix M, Van Hook J. "A Demographic, Socioeconomic and Health Coverage Profile of Unauthorized Immigrants in the United States." Washington, DC: Migration Policy Institute. May 2013.