Health Care Access for Adult Immigrants in Washington State

The Implications and Potential of Health System Reform

Patricia Lichiello, University of Washington Health Policy Center Initiative
In the U.S., immigrant access to publicly sponsored health care coverage programs has undergone significant federal and state regulatory change over the past 15 years—since the mid-1990s. The Patient Protection and Affordable Care Act (the ACA), passed in 2010 and affirmed by the U.S. Supreme Court in June 2012, is the most recent federal law to bring change to immigrant coverage options.

Immigrants’ access to health care services is a companion issue. Access to services is very often determined by an ability to attain health care coverage, but it is always predicated on whether health care providers are available to offer those services. For a great many adult immigrants in the U.S., the safety-net providers in our health system—for example, community clinics and health centers, and hospital emergency rooms—are the primary source of health care services. These providers, either by their own commitment or by order of law (for example, EMTALA, the Emergency Medical Treatment and Active Labor Act), will often offer some level of health care services to adult immigrants despite fluctuations and modifications in the various health care coverage programs designed to help pay for them.

Immigrant Eligibility for Publicly Sponsored Health Care Coverage Programs

Adult immigrants’ eligibility for federal and state health care coverage programs depends on three factors: the federally defined status of the immigrant, federal coverage laws, and state and local coverage laws.

• **Immigrant status** means the “type” of immigrant you are at the time you apply for health care coverage benefits. Box A offers five key immigrant status definitions. Each is based on 1) the reason the person has entered the U.S., and 2) the timing of entry. These definitions are critically important to understanding adult immigrants’ eligibility for health care coverage. Note that immigrant status is defined primarily by the U.S. Citizenship and Immigration Services (USCIS). Some federal and state laws have created different status definitions, however, that require the agencies that
implement them to issue interpretations consistent with USCIS definitions.

• Federal laws and regulations that identify the immigrant status each public program can serve. Immigrants who can be served by public programs are grouped under the classification qualified; immigrants who cannot be served are non-qualified. Some non-qualified immigrants are in a waiting period to become qualified. These two classifications are explained in Box B.

• State laws and regulations that identify the immigrant status each public program can serve. State programs also use the qualified and non-qualified classification system, but under some federal-state partner programs, including Medicaid, states may use their own funds to cover immigrants who are non-qualified for federal benefits.

Federal-State Partnership Health Care Coverage Programs

Several federal-state partnership programs allow for various types of health care coverage for adult immigrants.

Medicaid

Medicaid is a jointly funded federal-state program that provides health coverage to a defined set of low-income individuals in programs that are administered by the states. Federal funding is matched with state funds for certain covered services. The federal Medicaid law establishes mandatory eligibility for certain groups and the services to be provided, but also gives states options to expand the populations covered and the services offered beyond the minimum standards.

Adult Immigrant Eligibility

In August 1996, the Federal Personal Responsibility and Work Opportunity Reconciliation Act, or PRWORA, created qualified and non-qualified classifications for immigrant status. It directed that all qualified immigrants who arrived in the U.S. prior to August 22, 1996, would be eligible for Medicaid benefits. For qualified immigrants arriving on or after August 22,
Box B: Immigrant Eligibility for Federal Benefit Programs
Qualified and Non-Qualified

**Qualified** This classification includes 1) lawful permanent residents, refugees, and asylees; 2) persons paroled into the U.S. for at least one year, granted withholding of deportation or removal, or granted conditional entry; and 3) under specific conditions, battered spouses and children, Cuban and Haitian entrants, and victims of severe human trafficking.

**Non-Qualified** Immigrants who do not fit into the qualified classification are by definition, non-qualified. They include 1) persons with temporary protected status; 2) asylum applicants; 3) other lawfully present immigrants (e.g., students and tourists); and 4) undocumented/unauthorized immigrants. Persons at one time given the status of Permanently Residing Under Color of Law (PRUCOL), which is now obsolete at the federal level and for many states, also fit into this classification. These were individuals who were residing in the U.S. without a legal status and about whom immigration authorities were aware, but had no plans for deportation or removal from the country.²

1996, PRWORA established a five-year waiting period before they become eligible for Medicaid. This is often referred to as the “five-year bar.” Some qualified immigrants are exempt from this bar, including refugees, asylees, and others exempt on humanitarian grounds (e.g., victims of severe human trafficking, and Iraqi and Afghan special immigrants); members of the military and veterans and their spouses and children; and lawful permanent residents with credit for 40 qualifying quarters of work.

Non-qualified immigrants are eligible for Medicaid coverage only in very limited instances: if they were receiving Supplemental Security Insurance (SSI) on August 22, 1996, or are certain American Indians born abroad.

**State Children’s Health Insurance Program (SCHIP)**

SCHIP also is a jointly funded federal-state program, originally passed in 1997 and designed specifically for children in families that earn too much to qualify for Medicaid but not enough to afford private insurance. States have leeway in using their federal SCHIP dollars: they may use them to increase Medicaid income limits; they may develop a new program separate from Medicaid with its own income limits; or they may create a combination of the two. Because Congress set aside a finite amount of money for SCHIP, states can use up all of their allotted dollars.

**Adult Immigrant Eligibility**

Although SCHIP is designed for children, it does allow states to offer eligibility for prenatal care to pregnant immigrant women, regardless of their immigration status (under the unborn child option). In 2009, the Children’s Health Insurance Program Reauthorization Act, or CHIPRA, allowed states to offer health care coverage to lawfully residing immigrant pregnant women for 60 days postpartum, as well – including during the PRWORA five-year bar. The term lawfully residing was a new, undefined status in the law; the U.S. Department of Health and Human Services interpreted the term to mean a person who is both lawfully present and who meets Medicaid residency requirements. States may elect to cover lawfully residing pregnant women either under Medicaid exclusively or under both Medicaid and CHIP.

**Federal Reimbursement of Emergency Health Services Furnished to Undocumented Aliens (Section 1011: Medicare Prescription Drug, Improvement and Modernization Act)**

This federally funded medical program, passed in 2003, is designed for people who otherwise would be eligible for Medicaid but are not because
of their immigration status; for example, they are *non-qualified* (including *undocumented*) or they are *qualified* but within the PRWORA five-year bar. In Washington State, this program is called the Alien Emergency Medical (AEM) program. The federal government has allotted a defined amount of dollars for the program overall, which are apportioned to states based on their relative percentage of *undocumented* immigrants (*aliens*). Persons applying for this coverage must have a documented emergency medical condition.

**Patient Protection and Affordable Care Act (ACA)**

The ACA is designed to decrease the number of Americans without health insurance. It expands eligibility for Medicaid to a national floor of 133% of the federal poverty level (FPL) ($11,170 for an individual or $23,050 for a family of four in 2012) with a standard 5% income disregard – effectively raising the limit to 138%. It also extends coverage to adults under age 65 who meet this income eligibility, do not have dependent children, and are not eligible for Medicare. The ACA provides full federal financing to the states for those newly eligible for Medicaid for the years 2014-2016 and then gradually phases this match down to 90% in 2020 and beyond. The ACA also subsidizes health care coverage for individuals with incomes between 133% and 400% of the federal poverty level who buy health insurance through new state-based Health Benefit Exchanges.

**Adult Immigrant Eligibility**

*Lawfully present* adult immigrants residing in the U.S. over five years who meet the 138% FPL income eligibility criterion will gain additional access to Medicaid under the ACA. Those residing in the U.S. for fewer than five years (i.e., within the five-year bar) with incomes between 138% and 400% FPL, who do not have access to affordable employer-sponsored coverage, will be eligible for subsidized coverage through state Health Benefit Exchanges. Those residing under five years with income below 138% will not be eligible for Medicaid but can purchase health care coverage through an exchange with the cost-sharing requirement that they pay 2% of their income.

*Undocumented* adult immigrants will be ineligible for Medicaid, as they are now, under the ACA, regardless of their income.
to the ACA individual coverage mandate) are prohibited under the ACA from buying through a state Health Benefit Exchange: they are ineligible to buy unsubsidized coverage through an exchange and ineligible for exchange subsidies. Undocumented immigrants do remain eligible for emergency care under Medicaid (see “Federal Reimbursement of Emergency Health Services Furnished to Undocumented Aliens,” above).

The ACA continues the policy of allowing states to cover immigrants ineligible for federal programs in state-funded programs.

National Health Care Coverage Uptake by Immigrants

In 2010 there were 21.4 million immigrants in the U.S., about 7% of the total population. That means that one out of every 14 people of any age in the country was a foreign-born person who was not a citizen. Fourteen percent of all immigrants – about three million people – were covered by Medicaid and other public programs. Thirty-nine percent had private health care coverage and 47% – about 10 million people – were without health care coverage; that is, uninsured. Immigrants accounted for one out of every five uninsured persons in the country that year. Estimates of the number of undocumented immigrants in the U.S. are difficult to generate and hard to come by. The Pew Hispanic Center has estimated that there were 11.2 million undocumented immigrants in the U.S. in 2010 – a little over half of all immigrants that year. Three years earlier, in 2007, there were 12 million. At that time, over half of undocumented immigrants were uninsured.

Washington State Health Care Coverage for Adult Immigrants

Washington State offers many health care coverage programs targeted to specific adults who are citizens of the U.S. who have financial need – often referred to as low-income adults. The State also has elected to offer health care coverage to federally qualified and non-qualified adult immigrants who meet all other eligibility criteria.

Several Washington State programs are funded now with a combination of federal and state dollars through a “Medicaid Transitional Bridge Waiver.” This mechanism allows the state to cover individuals now who will become eligible for Medicaid in 2014 under the new income and age eligibility criteria. Three such programs include:

- Medical Care Services for adults age 18-65 unable to work due to physical or mental health disability.
- ADATSA for adults age 18-65 unable to work as a result of drug or alcohol abuse.
- Basic Health for Washington State residents ineligible for Medicare or Medicaid, who have legal documentation and income <200% FPL.

Other health care coverage programs offered by the state are funded through other combinations of federal and state dollars, or by state-only dollars: for example, Take Charge Family Planning, Family Planning Extension, and Breast and Cervical Cancer Treatment Program.

Undocumented Adult Immigrants in Washington State

In 2010, Washington State had 217,000 undocumented immigrant residents: 4% of the state’s total 5.9 million population under age 65. Washington was one of 17 states that year that offered state-only-funded health care coverage to non-qualified immigrants, which for Washington included undocumented immigrants. Still, there were 83,600 undocumented immigrants in Washington State under age 65 without health care coverage that year, 11% of the state’s total
of 786,400 under 65 residents without health care coverage.9


The health care coverage offered by some current state programs will no longer be available to some adult immigrants in 2014, particularly some qualified immigrants who do not meet residency and income thresholds, and non-qualified immigrants – including undocumented. Undocumented immigrants, in particular, also will be ineligible for primary care services through Medicaid, and will be prohibited from purchasing health care coverage, subsidized or not, through the state Health Benefit Exchange. If the State chooses to implement a new Basic Health Program Option offered by the ACA, which is a non-Medicaid alternative funding mechanism for specific low-income people, undocumented immigrants will not be eligible to participate in this program, either.

Although federal and state-sponsored health care coverage programs will be curtailed for many adult immigrants in 2014, their need for health care services will persist. The fundamental policy question for the State and other stakeholders in this issue – including health care providers, especially safety-net providers; health insurers and health plans; advocacy organizations; community organizations; the business community; and adult immigrant communities – is this:

*With implementation of the ACA, what is the state’s role in supporting access to the health care services that adult immigrants, especially those not eligible for federal programs, need?*

To answer this question, all stakeholders must consider a range of factors, such as cost (the costs of providing or not providing health care coverage programs, and who bears them); availability of private-sector health care coverage and services for these adults; and the effects of coverage and health care access loss on communities, businesses, and families.

**References for material cited in this briefing paper**