Immigrants and Health Care Reform
What's Really at Stake?

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Executive Summary

The health care reform legislation being drafted in Congress holds the promise of delivering coverage to millions of uninsured people in the United States through Medicaid expansion, private insurance subsidies, and mandated employer coverage. The scope and success of reform, however, will be affected substantially by lawmakers' decisions regarding the eligibility of legal immigrants for health benefits, and their approaches to screening out unauthorized immigrants. Their decisions will help determine how close Congress comes to its goal of reducing the ranks of the nation's 46 million uninsured.

Despite high workforce participation rates, many immigrants (regardless of their legal status) are uninsured. Yet some proposals under consideration in Congress would deny core benefits to many *legal* immigrants. These proposals would leave many legal immigrants outside a reformed health care system, with costly spillover consequences for taxpayers, health care consumers, and providers.

Lawmakers also intend to exclude *unauthorized* immigrants from any new benefits. While most agree that unauthorized immigrants should not benefit from government spending, lawmakers confront important questions about how to exclude them without creating a large and expensive screening bureaucracy and without imposing difficult verification burdens on US citizens and legal immigrants.

To guide our policy analysis, this report offers detailed new estimates, based on Migration Policy Institute (MPI) analysis and imputation of Census Bureau data, which provide a portrait of immigrants by legal status, current health insurance coverage, and variations in coverage across large immigrant states.[1]

The report provides a roadmap of the key health reform issues, focusing in particular on two populations likely to remain at the center of policy debates: lawful permanent immigrants (LPRs) with less than five years of legal residency, and unauthorized immigrants. It addresses legal immigrants' eligibility for Medicaid and health insurance subsidies and their inclusion in individual mandates, and strategies for screening out unauthorized immigrants.

[1] This analysis draws on data from the US Census Bureau's 2008 US Current Population Survey, Annual Social and Economic Supplement (CPS-ASEC). The data we employ include unique assignments of legal status to noncitizens created by Jeffrey S. Passel of the Pew Hispanic Center. See Jeffrey S. Passel and D'Vera Cohn, *A Portrait of Unauthorized Immigrants in the United States* (Washington, DC: Pew Hispanic Center, 2009). http://pewhispanic.org/files/reports/107.pdf. The assignments are necessary because the Census Bureau does not seek or report information about the legal status of noncitizens. MPI researchers conducted analysis of demographics, income, work patterns, and health insurance coverage using these data.

A. Snapshot of Immigrants and Their Health Care Coverage

Lawful Permanent Residents
Our estimates suggest there are roughly 12 million LPRs in the United States; 4.2 million are uninsured. These immigrants have "played by the rules" and waited their turn — in some cases for many years — to enter the United States, and they pay the same taxes and are subject to the same laws as US citizens. The 1996 welfare reform law instituted a five-year waiting period after obtaining a green card during which LPRs are ineligible for Medicaid.

A high proportion of LPRs fall into the low- to moderate-income groups targeted by health insurance reform. The vast majority has family incomes below 400 percent of the federal poverty level (FPL), the cutoff for subsidies under some legislative proposals, so purchasing private insurance would be eased by subsidies. However, lawmakers are conflicted about whether to include all LPRs in health care reform, or to leave in place the 1996 welfare reform restrictions on Medicaid. The decision to retain the five-year waiting period for Medicaid eligibility or to apply it to new insurance subsidies would affect over 1 million LPRs — thus limiting the potential for health reform to reduce the ranks of the uninsured.

Most LPRs work, meaning that proposed mandates requiring employers to provide health insurance would improve their coverage. Yet 38 percent of LPR workers are employed by small firms (fewer than 25 employees) that likely would be exempt from employer mandates, suggesting many might not get coverage. Just 32 percent of LPRs employed by small firms are insured, compared with 71 percent of the native born working in similar-sized firms.

We estimate that half of LPRs overall currently have employer coverage and one-third (3.9 million) are uninsured, accounting for 9 percent of the overall uninsured population. Almost all uninsured LPRs (93 percent) are adults, so the cost of providing coverage to uninsured LPR children (who are twice as likely as US-born children to be uninsured) would be quite low.

Unauthorized Immigrants
There are an estimated 12 million unauthorized immigrants in the United States. They are ineligible for Medicaid and other means-tested federal benefits, though hospitals may be reimbursed through Medicaid for providing emergency services. Notwithstanding the recent political furor over the issue, none of the pending legislative proposals would provide coverage for unauthorized immigrants. However, verification systems to screen them out of subsidies and the proposed insurance exchanges may be expensive and may have unintended consequences for US citizens and legal immigrants.

Unauthorized immigrants are disproportionately likely to have low incomes, and although most of them work, they are even more likely than LPRs (46 percent) to work at small firms that do not provide insurance. As a result, most unauthorized immigrants (6 million working-age adults and 660,000 children) are uninsured, accounting for 15 percent of the overall uninsured. Yet it is not widely recognized that 31 percent of unauthorized immigrants (some 3.2 million working-age adults and 460,000 children) already have employer coverage.

Disproportionate Impact on Large Immigrant States
States with large immigrant populations stand to benefit from health care subsidies extended to LPRs. The same states will, of course, bear a disproportionate burden if LPRs in the five-year waiting period remain ineligible for Medicaid and are excluded from insurance subsidies. States with large immigrant populations could see an expansion in the use of emergency rooms and public clinics if LPRs or unauthorized immigrants are dropped from employer-sponsored insurance or other private coverage on account of health care reform. Twenty-three percent of the uninsured in California are LPRs, and an additional 23 percent are unauthorized, according to our estimates. LPRs also represent more than 10 percent of the uninsured in New York, Texas, Florida, New Jersey, and Illinois.

B. Implications for Health Care Reform

Health Insurance Coverage
Many LPRs cannot afford health insurance. We estimate that 3.1 million working-age adult LPRs have incomes below 150 percent of FPL and that 4.1 million have incomes between 150 and 400 percent of FPL. Almost half of these two groups (3.4 million LPRs) lack health insurance, including more than 1 million who would be excluded from subsidies if Congress were to impose a five-year waiting period. If recent LPRs were denied eligibility for Medicaid and subsidies but still subjected to individual health insurance mandates, they would face a significant financial burden.

Exclusion of recent LPRs — as well as unauthorized immigrants — from health insurance reform would leave large populations still dependent on emergency rooms, community health centers, and other public health facilities, and would discourage early detection and treatment of chronic conditions. Thus, some of the short-term cost savings from excluding some immigrants from health care reform would be lost through cost shifting to state and local providers. Ultimately taxpayers and health care consumers would have to pay for uncompensated care for uninsured immigrants as well as higher health care costs in the future. Moreover, because recent LPRs (and unauthorized immigrants) are relatively young and healthy, including them in health insurance risk pools could help contain costs.

It is also noteworthy that since welfare reform's enactment in 1996, lawmakers have sought to expand coverage for legal immigrants, most recently by extending Medicaid and Children's Health Insurance Program (CHIP) eligibility to all LPR children and pregnant women. New exclusions from subsidies in health reform legislation would reverse this policy trajectory, raising issues that Congress may have to revisit in the future.

Verification
Another critical policy issue is whether the benefits of health care reform would be reduced by expensive and ineffective verification requirements. Though meant to ensure that unauthorized immigrants cannot wrongly access benefits, a verification mandate, if poorly designed, could have the biggest impact on US citizens.

There are two basic screening models: one based on screening individual applicants before they apply for benefits, as in the Medicaid system. The other links payments to tax credits

and screens legal status at the time benefits are paid, as in the Earned Income Tax Credit (EITC) program. Individual pre-screening is a more expensive model, especially if screeners are required to check documents such as birth certificates or passports. Recent experience with Medicaid suggests fraudulent use by unauthorized immigrants is very rare, raising questions about the need for costly front-end document checks.

One concern is that verification approaches might screen out many US citizens and legal immigrants from programs for which they are eligible, or force them to face costly delays in obtaining coverage. The introduction of document checks by the 2005 Deficit Reduction Act (DRA) led to thousands of vulnerable US citizens losing Medicaid or facing delays in their coverage.

In sum, despite the complexity of the issues and the heated political debate, health care reform offers policymakers an opportunity to get eligibility and verification right — one that should not be missed.

I. Introduction

In the current climate, health care and immigration are separately two of the most controversial policy issues. Taken together they seem to become even more complex and heated. This report addresses their intersections and attempts to shed some light on current policy debates using a recent Migration Policy Institute (MPI) analysis of US Census Bureau 2008 data. Although the outcomes of policy deliberations around health care and immigration reform may turn on public perceptions and debates over values, we hope to provide a factual foundation for these debates. To this end, we present new statistics about immigrant populations and their health care coverage, and discuss these numbers in the context of the health care reform proposals that most directly affect immigrants and the overall US population.

We begin by describing the demographics and health care coverage of two immigrant populations at the heart of current policy debates: recent lawful permanent residents (LPRs) and unauthorized immigrants.[2] LPRs are legal immigrants who have entered the country with the consent of the US government, in some cases waiting many years for a green card.[3] Like citizens, LPRs pay taxes and must register for the Selective Service. The Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA) of 1996 — also known as welfare reform — imposed a five-year waiting period for LPRs to become eligible for Medicaid and most other federal programs.[4] The primary rationale for the waiting period was that most LPRs are sponsored by family members or employers who should assume responsibility for them during their first few years in the United States.

Unauthorized immigrants either enter the country illegally or overstay valid visas.[5] Unauthorized immigrants are not now, nor have they been, eligible for Medicaid and other federal benefits, though hospitals may be reimbursed for providing them with emergency services. None of the pending health insurance reform proposals in Congress would authorize new benefits for unauthorized immigrants.

[2] We define recent LPRs as immigrants who received their green card within less than five years. Under the 1996 welfare reform law, LPRs are not eligible for Medicaid and most other federal means-tested programs until five years after they obtain legal permanent residence.

[3] We define LPRs as immigrants who hold green cards but have not yet become citizens. Our LPR group includes refugees and asylees but excludes nonimmigrants such as international students, temporary workers, other temporary visitors, and applicants for LPR status. Naturalized citizens are immigrants who have taken the citizenship test or otherwise qualified for US citizenship; their eligibility for Medicaid and other programs was not restricted by welfare reform, and there are no plans to restrict their eligibility for benefits under health care reform.

[4] This five-year waiting period was extended to the Children's Health Insurance Program (CHIP) when it was created in 1998. However, the 2009 CHIP reauthorization gave states the option to restore Medicaid and CHIP eligibility for recent LPR children and pregnant women.

[5] This group includes some unauthorized immigrants who have applied for green cards and may later become LPRs.

A. Central Health Reform Questions Affecting These Populations

The health care system in place today provides government-funded insurance to low-income and elderly Americans through Medicaid and Medicare, while most — but not all — other Americans obtain private coverage through their employers or by purchasing individual private plans. More than 46 million people are uninsured, and an overarching goal of health care reform is to extend insurance to most of these people.

Because the health care debate remains highly fluid, this report does not analyze any single proposal in detail, but focuses in general on the reform proposal outlined by President Obama in his address to Congress on September 9; on bills passed by the House Committee on Energy and Commerce, the House Committee on Ways and Means, and the House Committee on Education and Labor; the Senate Committee on Health, Education, Labor and Pensions; and on the bill under consideration, at the time of this writing, by the Senate Finance Committee. There are four principal ways in which all of these proposals would reform the system:

- **Expansion of Medicaid coverage**. The proposals would expand Medicaid to cover a larger group of low-income Americans, mainly by making the program available to low-income adults and by raising the income levels under which children qualify for public coverage.[6]

- **Health insurance subsidies.** For people whose incomes are too high to qualify for Medicaid, but who are too poor to afford private insurance and do not get insurance through their employers, the proposals would offer subsidies to help offset the costs of purchasing insurance.[7] These subsidies, which could take the form of tax credits, would be available for policies purchased through new health insurance exchanges.

- **Health insurance exchanges.** All current congressional proposals would create exchanges through which families and individuals lacking employer or public coverage could purchase their own health insurance. Some proposals include a public option (i.e., a government-run plan as a low-cost alternative to private insurance) that would be available through these exchanges. Some individuals would qualify for subsidies to purchase insurance through the exchanges, while others would pay the full cost of the insurance.

- **Individual and employer mandates**. The proposals would promote universal coverage by requiring most employers to provide health insurance for their employees (or giving

[6] States set their own rules for Medicaid eligibility but must meet various federal guidelines. Currently, Medicaid is available to various covered groups (children, pregnant women, disabled people, etc.) but not to most childless adults; reform proposals would permit coverage for childless adults (and others) with incomes up to 133 or 150 percent of federal poverty level (FPL), depending on the proposal. States currently must cover children with incomes up to 100 or 133 percent of FPL; the Senate Finance Committee proposal would raise this threshold to 250 percent of FPL.

[7] The eligibility thresholds for subsidies vary depending on the specific congressional proposal but range at the bottom end from 133 to 150 percent of FPL — the proposed eligibility limits for adults in Medicaid — and at the top end from 300 to 400 percent of FPL.

incentives for them to do so), and by requiring most individuals to obtain health insurance, using the insurance exchanges in cases where their employers do not provide coverage. Individuals could also purchase private insurance outside the exchanges, but private markets would likely shrink once the exchanges were created.

Reform proposals raise two sets of questions with implications for immigrants and immigration policy. The first bears on whether proposed subsidies and mandates will apply to recent LPRs. As lawmakers expand Medicaid coverage for US citizens and long-term LPRs, will they overturn the five-year waiting period passed in 1996 and make recent LPRs eligible for these benefits, as some have proposed? Will moderate-income recent LPRs be eligible for health insurance subsidies? Will individual mandates apply to LPRs even if they are ineligible for Medicaid or insurance subsidies?

The second set of questions bears on how to verify the legal status of people obtaining insurance benefits. Lawmakers intend to exclude unauthorized immigrants from any new benefits, but they confront important questions about how to do so without creating a large and expensive screening bureaucracy and without imposing additional burdens on US citizens and legal immigrants. Will verification rely exclusively on electronic screening, or will screeners examine identification documents? At what point will screening occur — at the time applications are filed or when expenditures are reimbursed? Will screening be limited to people applying for Medicaid and insurance subsidies, or will people buying their own insurance through exchanges also be screened? Will private employers and insurance providers be required to play a screening role, or only the government?

II. A Snapshot of Immigrant Health Care Coverage

To address these questions we turn to our analysis of the latest data from the US Current Population Survey (CPS).[8]

[8] The analysis in this report draws on data from the 2008 US Current Population Survey, Annual Social and Economic Supplement (CPS-ASEC). Our analysis has been augmented with techniques developed by Jeffrey S. Passel of the Pew Hispanic Center to assign legal status to noncitizens — allowing us to estimate numbers and characteristics of legal immigrants and unauthorized immigrants. See Jeffrey S. Passel and D'Vera Cohn, *A Portrait of Unauthorized Immigrants in the United States* (Washington, DC: Pew Hispanic Center, 2009). http://pewhispanic.org/files/reports/107.pdf. The data in the CPS-ASEC also allow us to differentiate by age group, income level, health insurance coverage, workforce participation, employer size, and, to a limited extent, by state. The figures we present here are estimates with significant margins of error, because legal status must be imputed and because of potential immigrant undercounts in the CPS-ASEC, but are generally within the range of estimates reported elsewhere. Additionally, the augmented data with legal status assignments are adjusted slightly to account for the undercount of legal and unauthorized immigrants in the original CPS-ASEC, and so our totals may differ slightly from totals published elsewhere using other versions of the data.

A. LPR and Unauthorized Immigrant Populations

There are about 38 million immigrants in the United States, amounting to 12.5 percent of the total population of 304 million. We estimate that they are approximately evenly divided among three groups — naturalized citizens, LPRs, and unauthorized immigrants — with between 12 and 14 million each. Official data from the US Department of Homeland Security (DHS) indicate 4.4 million LPR admissions within the past five years; or 36 percent of the estimated 12.3 million LPRs in the United States in 2008.[9] Several million people are therefore affected by policies requiring a five-year waiting period for legal immigrants.

Together, LPRs, unauthorized immigrants, and smaller groups of temporary visitors (students, workers, and others) add up to about 25 million noncitizens.[10] When researchers, advocates, or lawmakers talk about "noncitizens," they lump together two very different groups: those who are in the United States legally and those here illegally.

Immigrants and their children are also often grouped together without regard for differences in their citizenship. There are currently about 11 million children with parents who are either LPRs or in the country illegally. Almost 9 million of these children are US-born citizens. Even among the 4.8 million children with unauthorized parents, 3.4 million (71 percent) are US-born. In fact, the majority of children of immigrants live in mixed-status families with citizen children and noncitizen parents.

B. Income and Poverty among Immigrant Populations

Family income is higher among citizens than legal and unauthorized immigrants. In 2007 about 27-28 percent of US-citizen children and 15-16 percent of working-age adults were low income (i.e., had family incomes below 150 percent of FPL, a proposed cutoff for eligibility under the Medicaid expansion and our definition of "low income" throughout this report).[11] Naturalized immigrants were no more likely than US-born citizens to be low income (see Table 1). By comparison, about a third of LPR adults, 40 percent of unauthorized adults, and half of LPR and unauthorized children were low income.

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[9] The estimate of 4.4 million LPRs with less than five years of legal residency is based on legal immigrant admissions during federal fiscal years 2004, 2005, 2006, and 2007; US Department of Homeland Security, *Yearbook of Immigration Statistics: Table 4, Persons Obtaining Legal Permanent Resident Status By State Or Territory Of Residence: Fiscal Years 1999 To 2008* (Washington, DC: Department of Homeland Security, 2008), http://www.dhs.gov/xlibrary/assets/statistics/yearbook/2008/table04.xls. The CPS data include the year in which immigrants arrived in the United States, but not when they became legal residents. Because about half of all LPRs adjust their status long after they arrive — sometimes many years later — the CPS data on year of arrival do not allow us to analyze accurately the population with less than five years of legal residency.

[10] Students, temporary workers, others with temporary statuses, and green-card applicants number less than 1 million and are excluded from our analysis.

[11] In this and subsequent analyses, we define children to include those ages 17 and under, while working-age adults are those ages 18 to 64. Elderly ages 65 and over are excluded from the analysis because most of them receive health care coverage through Medicare, and they are not the focus of the current health care reform initiative. Note that poverty-level income is reported for the year prior to the survey (2007).

The cutoff point for eligibility for health insurance subsidies is likely to be set at either 300 or 400 percent of FPL — levels that would include the majority of immigrants and their children. In 2007 over 80 percent of both LPR and unauthorized children had incomes below 400 percent of FPL, higher than the rate for citizen children. Among adults, 70 percent of LPRs and over 80 percent of unauthorized immigrants had incomes below 400 percent of FPL, which we define as "moderate income."[12]

Table 1. Family Incomes of Children and Working-Age Adults, 2007

	US-Born Citizens %	Naturalized Citizens %	Lawful Permanent Residents %	Unauthorized Immigrants %
Children (ages 0-17)				
Percent low income: less than 150% of FPL	28.6	26.7	48.6	52.1
Percent moderate income:				
less than 300% of FPL	56.7	52.5	72.3	82.2
less than 400% of FPL	70.4	62.0	83.0	88.0
Working-Age Adults (ages 18-64)				
Percent low income: less than 150% of FPL	16.6	15.2	31.1	40.4
Percent moderate income:				
less than 300% of FPL	39.2	40.2	59.3	75.5
less than 400% of FPL	53.7	54.6	71.8	86.1

Source: MPI analysis of US Current Population Survey (CPS), Annual Social and Economic Supplement, March 2008, augmented by assignments of legal status to noncitizens provided by Jeffrey S. Passel at Pew Hispanic Center. For methodological details see Jeffrey S. Passel and D'Vera Cohn, 2009, *A Portrait of Unauthorized Immigrants in the United States,* Washington, DC: Pew Hispanic Center.

C. Patterns of Work among Immigrants

The vast majority of immigrants work. In 2008, the labor force participation of unauthorized immigrants was 80 percent; it was 72 percent for LPRs and 77 percent for US-born citizens. The share of immigrants who worked at least part time was also high: 72 percent for unauthorized immigrants and 65 percent for LPRs, versus 70 percent for the US born.[13] Over 90 percent of working immigrants — both legal and unauthorized — worked full time.

D. Employer Coverage of Working-Age Immigrants and Children

Despite immigrants' high workforce participation rates, employer-sponsored health insurance coverage is much lower among LPRs than among US-born citizens and naturalized citizens. About two-thirds of working-age adults who were citizens had employer

[12] We provide figures in the tables for family income below 300 percent of FPL, as that is the threshold for subsidies in some congressional proposals.

[13] These labor force participation and part-time work rates (defined as 26 weeks full time or 1,000 hours in total during the year) are for adults age 18-64 in the civilian labor force. Hours and weeks of work are for the previous year (2007).

coverage in 2007, compared with less than half of LPR adults (see Table 2).[14] We estimate that 4.6 million LPR working-age adults had employer coverage in 2007 and that 1.6 million of these LPRs had less than five years of legal permanent residency.[15]

Employer-sponsored coverage of LPR children lagged that of adults (38 percent versus 46 percent). Nonetheless, about 400,000 LPR children had employer coverage. Both these children and US-born children with LPR parents would stand to be without health insurance if their parents lost employer coverage. Since LPR and US-born children are eligible for Medicaid and CHIP, any policy change that would make it difficult for LPR parents to maintain their employer coverage could shift their children from private to public coverage, increasing the burden on public programs.

Among low-income adults and children, employer coverage was relatively low: 15 percent for LPR adults and 11 percent for LPR children. These very low employer coverage rates mean that the vast majority of low-income recent LPRs are likely to remain uninsured unless they are eligible for Medicaid or CHIP.

Among the moderate-income group, half of adult citizens but only a third of LPRs had employer coverage. If recent LPRs were denied the opportunity to obtain insurance subsidies under existing health reform proposals, a majority likely would remain uninsured.

Overall 3.2 million unauthorized adults (31 percent) had employer coverage. Thus policies which discourage employers from providing coverage to unauthorized immigrants could push some into uninsured status.

Table 2. Percentage of Working-Age Adults and Children with Employer Coverage, 2007

	US-Born Citizens %	Naturalized Citizens %	Lawful Permanent Residents %	Unauthorized Immigrants %
Children (ages 0-17)				
Overall	61	60	38	31
Low income: less than 150% of FPL	22	18	11	16
Moderate income:				
less than 300% of FPL	42	36	22	23
less than 400% of FPL	49	43	29	25
Working-Age Adults (ages 18-64)				
Overall	67	64	46	31
Low income: less than 150% of FPL	21	19	15	14
Moderate income:				
less than 300% of FPL	43	43	28	22
less than 400% of FPL	52	50	34	26

Source: MPI analysis of CPS Annual Social and Economic Supplement, March 2008, augmented by assignments of legal status to noncitizens provided by Pew Hispanic Center.

[14] Insurance coverage is reported for the year prior to the survey.

[15] Here and throughout the rest of the report, our estimates for populations of LPRs with less than five years of legal residency are based on the overall share of LPRs with less than five years of residency divided by the total LPR population (36 percent).

E. Variation in Employer Coverage by Employer Size

Immigrants are more likely than US-born workers to be employed by small firms that do not provide health care coverage. In 2008, 38 percent of working LPRs worked for firms with fewer than 25 employees, compared with 28 percent of US-born workers. Just 32 percent of LPRs working in these small firms had employer coverage (see Table 3). This means a mandate requiring employers of 25 or more workers to provide health insurance coverage would exclude a significant number of LPR workers. Raising the threshold for an employer mandate would leave even more LPRs uncovered.[16]

Thus, the absence of a coverage mandate for all employers would affect immigrants more than natives in two ways: immigrants are more likely to work for smaller employers, and smaller employers are less likely to provide them with health coverage. This is true both for LPRs and unauthorized immigrants — an even higher share of whom works for the smallest firms.

Table 3. Percentage of Workers* with Employer Coverage by Firm Size, 2007

	US-Born Citizens	Naturalized Citizens	Lawful Permanent Residents	Unauthorized Immigrants
Firm Size (number of employees**				
Fewer than 25	71	48	32	22
25 to 99	82	73	53	35
100 to 499	87	77	67	51
500 to 999	89	85	71	57
1,000 or more	89	88	78	57

Notes: * Workers are working-age adults (age 18 to 64) who worked at least 26 weeks full time or a total of 1,000 hours or more in 2007.
** The data do not allow disaggregation of firm size at levels other than those listed in the table.
Source: MPI analysis of CPS, Annual Social and Economic Supplement, March 2008, augmented by assignments of legal status to noncitizens provided by Pew Hispanic Center.

F. Medicaid/CHIP Coverage

Overall, LPRs are more likely than citizens to be covered by Medicaid or CHIP, but this pattern owes to the fact that they are less likely to have employer-sponsored coverage, as noted above, and that they are more likely to have low incomes. In 2007, 23 percent of low-income LPR adults had Medicaid coverage, about the same rate as citizen adults (see Table 4). Among low-income children, 55 percent of LPRs had Medicaid or CHIP coverage, slightly below the share for US-born citizen children (58 percent).

In 2007, when these data were collected, many of the LPRs who received Medicaid or CHIP coverage actually were enrolled in *state* health insurance programs operated without federal

[16] Some proposals would require businesses with 50 or more employees to provide coverage. Data are not available to estimate employer coverage rates for people working at firms below this threshold; but the proportion of LPRs covered likely falls between estimates for firms with fewer than 25 employees (32 percent) and those with fewer than 100 (53 percent).

funding. The 1996 welfare reform law barred LPRs with less than five years of legal residency from federally funded Medicaid or CHIP, but states are permitted to cover recent LPRs using their own funds.[17]

Unauthorized immigrants are ineligible for the regular Medicaid and CHIP programs, and so were excluded from our analysis. A significant number, however, may receive emergency care at public hospitals, which is typically either reimbursed through Medicaid or written off by the hospital as uncompensated care. We did not develop an estimate of this number, as the data from the CPS on this topic are considered unreliable.[18]

Table 4. Percentage Working-Age Adults and Children with Medicaid/CHIP Coverage*, 2007

	US-Born Citizens %	Naturalized Citizens %	Lawful Permanent Residents %
Children (ages 0-17)			
Overall	23	18	33
Low income: less than 150% of FPL	58	45	55
Moderate income:			
less than 300% of FPL	39	33	44
less than 400% of FPL	32	28	39
Working-Age Adults (ages 18-64)			
Overall	7	7	10
Low income: less than 150% of FPL	26	24	23
Moderate income:			
less than 300% of FPL	15	14	16
less than 400% of FPL	11	11	14

Notes: * Some unauthorized immigrants may receive coverage at the state or local level through special programs, but they are ineligible for federally funded Medicaid and CHIP, and so are not included in our analysis.
Source: MPI analysis of CPS, Annual Social and Economic Supplement, March 2008, augmented by assignments of legal status to noncitizens provided by Pew Hispanic Center.

[17] Several states, including some of the largest immigrant states (California, New York, Illinois, and Massachusetts), have extended Medicaid/CHIP coverage to recent LPRs for most of the period since 1996. In January 2009, Congress restored the eligibility of recent LPR children for federally funded Medicaid and CHIP as a state option, thereby allowing states to obtain a federal match to cover these children; but recent LPR adults remain under the five-year bar, and are only eligible for fully state funded insurance programs in 12 states — a policy under strain during a time of state budget crises. See National Immigration Law Center, "TABLE 10: State-Funded Medical Assistance Programs," *Guide to Immigrant Eligibility for Federal Programs*, March 2009, http://www.nilc.org/pubs/guideupdates/tbl10_state-med-asst_2007-07_2009-03.pdf.

[18] The Congressional Budget Office (CBO) recently estimated that up to 1 million unauthorized immigrants (about 10 percent) might make use of emergency Medicaid services in 2019, ten years after passage of health care reform. See Douglas W. Elmendorf, Director, CBO, letter to Charles Grassley, Ranking Member, Committee on Finance, US Senate, September 22, 2009, http://www.cbo.gov/ftpdocs/106xx/doc10619/09-22-GrassleyLtr.pdf.

G. The Uninsured

LPRs are much more likely to be uninsured than citizens because of lower incomes, lower employer coverage, and bars on eligibility for public programs. In 2007, LPRs were more than twice as likely as US-born citizens to be uninsured. A quarter of LPR children were uninsured, versus just 10 percent of US-born citizens (see Table 5). Thirty-seven percent of LPR adults were uninsured, versus just 16 percent of US-born citizens. Low incomes and exclusion from benefits also translate into lack of coverage for unauthorized immigrants. In 2007, 55 percent of unauthorized immigrant children and 59 percent of unauthorized immigrant adults were uninsured.

Low incomes are more highly correlated with lack of health insurance coverage among adults than children. In 2007, there were large differences in insurance coverage rates between low-income adults and all adults, both among citizens and noncitizens. But differences in coverage rates were much lower between low-income children and all children because public programs provided a substantial boost in the insurance coverage of low-income citizen and LPR children. Public programs did not significantly boost coverage of low-income unauthorized immigrant children, 53 percent of whom were uninsured.

Table 5. Percent Uninsured for Working-Age Adults and Children, 2007

	US-Born Citizens %	Naturalized Citizens %	Lawful Permanent Residents %	Unauthorized Immigrants %
Children (ages 0-17)				
Overall	10	14	25	44
Low income: less than 150% of FPL	16	23	30	53
Moderate income:				
less than 300% of FPL	14	20	30	51
less than 400% of FPL	13	20	27	49
Working-Age Adults (ages 18-64)				
Overall	16	20	37	59
Low income: less than 150% of FPL	37	43	56	73
Moderate income:				
less than 300% of FPL	29	33	51	67
less than 400% of FPL	24	29	47	64

Source: MPI analysis of CPS, Annual Social and Economic Supplement, March 2008, augmented by assignments of legal status to noncitizens provided by Pew Hispanic Center.

Despite their higher rates of health care coverage, US-born citizens are a large majority of uninsured Americans. Only 29 percent of the uninsured were immigrants — 15 percent unauthorized, 9 percent LPRs, and 5 percent naturalized (see Table 6). We estimate that in 2007 there were close to 11 million noncitizens without health care coverage — 6.8 million unauthorized immigrants and 4.2 million LPRs. An estimated 1.4 million uninsured LPRs had less than five years of legal residency.

The vast majority of the 11 million uninsured noncitizens were adults; in fact, fewer than 1 million noncitizen children lacked health insurance coverage. Together, the 667,000 unauthorized immigrant and 273,000 LPR children accounted for just 11 percent of all children without coverage, and only 2 percent of the overall uninsured population of 46.6 million. The number of uninsured LPR children with less than five years of residency is likely below 100,000. Extending some form of public coverage to these uninsured children would represent a modest cost, especially compared with the overall cost of health care reform.

Table 6. Number of Uninsured Adults and Children, 2007 (thousands)

	Children (0-17)	Adults (18 & older)	Children and Adults (total)	Percentage of Uninsured (total)
US-born citizens	7,165	26,033	33,198	71%
Naturalized citizens	63	2,210	2,274	5%
Lawful permanent residents	273	3,933	4,206	9%
Unauthorized immigrants	667	6,090	6,757	15%
Total	8,175	38,409	46,584	100%

Notes: The population totals in this table may vary slightly from totals published using the public-use CPS data. The augmented data we use are adjusted slightly to account for the undercount of legal and unauthorized immigrants, resulting in slightly higher population totals. Totals do not add up because a small group of temporary visa holders such as students and temporary workers is excluded from our analyses; this group is largely excluded from eligibility for public health insurance programs.
Source: MPI analysis of CPS, Annual Social and Economic Supplement, March 2008, augmented by assignments of legal status to noncitizens provided by Pew Hispanic Center.

H. Disproportionate Impact on Large Immigrant States

Health reform will be implemented in vastly different coverage environments across the states. While employer coverage is lower for immigrants than natives across the country, there are clear regional patterns: higher coverage for all populations in the North and East, lower coverage in the South and West. Less than half of LPRs have employer coverage in the four largest immigrant states of California, New York, Texas, and Florida (see Table 7).

Table 7. Percentage of Working-Age Adults with Employer Coverage, United States and States with Largest Immigrant Populations,* 2005-2007**

	US-Born Citizens %	Naturalized Citizens %	Lawful Permanent Residents %	Unauthorized Immigrants %
United States	**67**	**65**	**47**	**31**
California	64	62	40	30
New York	68	64	44	29
Texas	61	56	36	25
Florida	63	64	44	31
New Jersey	76	74	57	35
Illinois	71	74	56	44
Georgia	66	67	57	25
Arizona	63	63	41	20
Massachusetts	73	67	56	44
Virginia	72	71	59	35
Maryland	75	77	57	31
Washington	69	66	61	37
North Carolina	64	74	44	25
Pennsylvania	72	70	66	49
Michigan	71	65	65	48

Notes: * Data for selected states are shown; these are the states with samples of immigrant populations large enough to analyze. States are ordered by the size of their overall immigrant populations.
** Three years of CPS, Annual Social and Economic Supplement data (March 2006, March 2007, and March 2008) are employed here to increase sample size and precision of the estimates.
Source: MPI analysis of CPS, Annual Social and Economic Supplement, March 2008, augmented by assignments of legal status to noncitizens provided by Pew Hispanic Center.

Uninsurance patterns are the reverse of employer coverage: they are higher in the South and West and lower in the North and East. In 2005-2007, the uninsured share of LPR adults ranged from 54 percent in Texas to 28 percent in New York (see Table 8).[19] The share of unauthorized immigrant adults who were uninsured ranged from 70 percent in Texas to 35 percent in Massachusetts.

[19] Our analysis of Massachusetts indicated an insurance rate of only 16 percent for LPRs, but the sample size on this estimate was too small to consider it reliable.

Table 8. Percentage of Uninsured Working-Age Adults, United States and States with Largest Immigrant Populations,* 2005-2007**

	US-Born Citizens %	Naturalized Citizens %	Lawful Permanent Residents %	Unauthorized Immigrants %
United States	**17**	**19**	**37**	**59**
California	17	20	42	55
New York	14	17	28	54
Texas	24	32	54	70
Florida	21	22	45	62
New Jersey	14	16	32	59
Illinois	15	16	33	52
Georgia	19	24	35	69
Arizona	19	***	36	69
Massachusetts	10	***	***	35
Virginia	14	19	33	61
Maryland	13	15	33	62
Washington	14	***	***	50
North Carolina	18	***	44	69

Notes: * Data for selected states are shown; these are the states with samples of immigrant populations large enough to analyze. States are ordered by the size of their overall immigrant populations.
** Three years of CPS, Annual Social and Economic Supplement data (March 2006, March 2007, and March 2008) are employed here to increase sample size and precision of the estimates.
*** Sample size too small to calculate reliable estimate.
Source: MPI analysis of CPS, Annual Social and Economic Supplement, March 2008, augmented by assignments of legal status to noncitizens provided by Pew Hispanic Center.

How immigrants are affected by health care reform has especially important implications for states with large uninsured immigrant populations. For instance, in California, almost half of all uninsured working-age adults are noncitizens — 23 percent LPRs and 23 percent unauthorized immigrants (see Table 9). LPRs are over 10 percent of uninsured adults in the other large immigrant states of New York, Texas, Florida, New Jersey, and Illinois. In Arizona and New Jersey, a quarter of all the uninsured are unauthorized immigrants. It will be expensive for these high-immigrant states to leave recent LPRs or unauthorized immigrants out of health care reform, because these populations will still use emergency rooms, community health centers, and other public health facilities. In these states, the cost of continuing to provide health care through emergency rooms and other public health facilities might partially reduce savings that flow from health care reform.

Table 9. Percentage of Uninsured Working-Age Adults Who Are LPRs or Unauthorized Immigrants, United States and States with Largest Immigrant Populations,* 2005-2007**

	Lawful Permanent Residents %	Unauthorized Immigrants %
United States	**10**	**15**
California	23	23
New York	13	18
Texas	13	18
Florida	13	18
New Jersey	13	24
Illinois	12	14
Georgia	5	17
Arizona	8	25
Massachusetts	***	13
Virginia	8	17
Maryland	9	20
Washington	***	11
North Carolina	5	16

Notes: * Data for selected states are shown; these are the states with samples of immigrant populations large enough to analyze. States are ordered by the size of their overall immigrant populations.
** Three years of CPS, Annual Social and Economic Supplement data (March 2006, March 2007, and March 2008) are employed here to increase sample size and precision of the estimates.
*** Sample size too small to calculate reliable estimate.
Source: MPI analysis of CPS, Annual Social and Economic Supplement, March 2008, augmented by assignments of legal status to noncitizens provided by Pew Hispanic Center.

III. Policy Implications

As health care reform is being vigorously debated in Congress and public arenas around the nation, lawmakers confront questions about which immigrants will be eligible for Medicaid and subsidies to help them purchase insurance, which ones will be eligible to make unsubsidized purchases in health insurance exchanges, and about the scope of individual mandates. In the remainder of this report, we discuss how many uninsured individuals would be affected by different eligibility schemes under these proposed reforms, the costs of including or excluding different immigrant groups, and the verification issues they raise. These proposals are summarized immediately below in Table 10.

Table 10. Summary of Selected Proposed Eligibility Rules and Verification Requirements for Noncitizens in Congressional Health Care Reform Proposals, as of October 2, 2009

	Lawful Permanent Residents	Unauthorized Immigrants	Verification Requirements
Medicaid	Five-year waiting period remains in place	Ineligible	Medicaid's use of SAVE system remains in place
Subsidies to purchase private insurance	Eligible without five-year waiting period	Ineligible	House bill and Senate Health, Education, Labor, and Pensions (HELP) Committee do not specify; Senate Finance Committee would require SAVE-style and tax screening
Participation in exchange to purchase unsubsidized insurance	Eligible	Ineligible under Senate Finance Committee; eligible under House bill and Senate HELP Committee	House bill and Senate HELP Committee do not specify; Senate Finance Committee would require SAVE-style screening
Individual mandates	Apply	Do not apply under Senate Finance Committee; apply under Senate HELP Committee and House bill; waivers possible under House bill	Not Applicable
Employer mandates	Apply	Apply	Not Applicable

Note: Table summarizes eligibility and verification requirements in House Resolution 3200, Senate Health, Education, Labor, and Pensions (HELP) Committee bill, and Senate Finance Committee Chairman's Mark as of October 2, 2009. Unless otherwise specified, information provided applies to all three proposals.

A. Eligibility Rules for Medicaid and Insurance Subsidies

Proposals for health care reform would expand insurance coverage for low-income individuals and families by mandating coverage for adults in Medicaid, raising income thresholds in the program, and by providing subsidies to help moderate-income people purchase insurance through new health insurance exchanges. We assume that unauthorized immigrants will be unaffected by these changes and will be excluded from any new subsidies, as President Obama and members of Congress have emphasized. Long-term LPRs would benefit from increased Medicaid coverage and from subsidies to help them purchase health insurance. But whether recent LPRs will have their eligibility restored for Medicaid, or if they will be made eligible for subsidies remains an open question.

The 4 million LPRs who are currently uninsured stand to gain from the proposed expansion of Medicaid and subsidies to purchase insurance through the exchanges. But the exclusion of recent LPRs from Medicaid or subsidies could reduce how many people benefit:

- About **3.1 million** working-age adult LPRs have incomes below 150 percent of FPL, making them potentially eligible for Medicaid; and 56 percent of these immigrants

(**1.8 million people**) lack health insurance. About **600,000** would likely be affected by the five-year waiting period, if it is not eliminated.

- We estimate that about **4.1 million** working-age adult LPRs have incomes between 150 and 400 percent of the federal poverty level, making them potentially eligible for subsidies. About **1.6 million** (39 percent) of these individuals lack health insurance, and about **550,000** would be affected by a five-year waiting period, if it were applied to subsidies.

Recent LPRs are concentrated in small firms with low insurance coverage rates, so many of these legal immigrants will only be able to afford health insurance if they are eligible for Medicaid or insurance subsidies.

Lawmakers may be reluctant to restore Medicaid coverage by waiving the five-year waiting period or to include recent LPRs in insurance subsidies because these policy changes would raise the short-term costs of health care reform. The average cost for Medicaid health services was $6,120 per enrollee in 2007, with the federal government paying 57 percent of these costs and states paying the remainder.[20] The Congressional Budget Office (CBO) estimates that subsidies will cost an average of $4,600 per enrollee in their first year, 2015, rising to $6,000 in 2019.[21]

These short-term cost estimates overstate the costs of including LPRs in Medicaid and insurance subsidies because immigrants are younger and healthier than native-born citizens, with lower disability and chronic disease rates.[22] Partly for these reasons, immigrants are less likely than natives to visit the emergency room.[23] Recent studies have found that immigrants spend 14 to 20 percent less on health care than natives even when controlling for their insurance coverage,[24] and that noncitizens spend less than half as much as citizens on health care overall.[25] Recent LPRs, therefore, cost less to insure than other Americans, and could lower insurance premiums for US citizens if included in the exchanges in large numbers.

In addition, any apparent savings from excluding some immigrants from Medicaid or insurance subsidies would be partly offset by cost shifts in two areas. First, people without health insurance would continue to use the health care system. Low-income people who cannot afford to visit a doctor often seek non-urgent care at emergency rooms, where they

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[20] Christopher J. Truffer, John D. Klemm, E. Dirk Hoffman, and Christian J. Wolfe, *2008 Actuarial Report on the Financial Outlook For Medicaid* (Washington, DC: Office of the Actuary, Centers for Medicare and Medicaid Services, US Department of Health and Human Services, 2008), http://www.cms.hhs.gov/ActuarialStudies/downloads/MedicaidReport2008.pdf

[21] Douglas W. Elmendorf, Director, CBO, letter to David Camp, Ranking Member, Committee on Ways and Means, US House of Representatives, July 26, 2009, http://www.cbo.gov/ftpdocs/104xx/doc10400/07-26-InfoOnTriCommProposal.pdf p. 15.

[22] Leighton Ku, "Health Insurance Coverage and Medical Expenditures of Immigrants and Native-Born Citizens in the United States," *American Journal of Public Health* 99, no. 7 (2009): 1322-1328.

[23] The Kaiser Commission on Medicaid and the Uninsured, *Kaiser Commission on Key Facts: Five Basic Facts on Immigrants and their Health Care* (Washington, DC: the Henry J. Kaiser Family Foundation, 2008), http://www.kff.org/medicaid/upload/7761.pdf.

[24] Ku, "Health Insurance Coverage and Medical Expenditures."

[25] The Kaiser Commission on Medicaid and the Uninsured, *Five Basic Facts on Immigrants and their Health Care.*

must be treated regardless of their immigration status or ability to pay.[26] When Massachusetts sought to save $130 million by eliminating recent LPRs from its state health insurance system, its state hospitals had to budget an extra $87 million for non-urgent emergency care, so the cost savings from limiting benefits were reduced by two-thirds.[27] And providing non-urgent care this way is inefficient because the same services cost eight to ten times as much in an emergency room as in more basic health settings.[28] Thus, CBO concluded that the emergency Medicaid costs associated with the care of immigrants left ineligible for regular Medicaid or insurance subsidies after health care reform could be significant.[29]

Second, excluding recent LPRs from Medicaid or insurance subsidies also shifts some health costs into the future because uninsured immigrants would be less likely to obtain preventive care and early detection of chronic conditions, resulting in more expensive future treatment.[30] Projecting these types of future costs is difficult because the savings from preventive care will emerge over decades — well outside CBO's ten-year scoring of reform proposals — and because immigrants' incomes could increase in that period, potentially allowing them to purchase private insurance.

Congress also is considering changing the poverty formula to make it more difficult for citizen children with unauthorized immigrant parents to qualify for health insurance subsidies. Most federal benefit programs — including Medicaid and CHIP — rely on a

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[26] The 1986 Emergency Medical Treatment and Labor Act (EMTALA) requires emergency rooms to examine and treat patients regardless of their legal status, citizenship, or ability to pay.

[27] Naomi Freundlich, "Health Care for Immigrants — When Insured, They Help All of Us," Health Beat blog by Maggie Mahar, July 30, 2009, http://www.healthbeatblog.com/2009/07/health-care-for-immigrantswhen-insured-they-help-all-of-us-.html.

[28] Miriam Jordan, "Illegal Immigration Enters the Health-Care Debate," *The Wall Street Journal*, August 15, 2009, http://online.wsj.com/article/SB125027261061432585.html.; also see American Hospital Association, *The Economic Crisis: The Toll on the Patients and Communities Hospitals Serve* (Washington, DC: American Hospital Association, 2009), http://www.aha.org/aha/content/2009/pdf/090427econcrisisreport.pdf.

[29] See Douglas W. Elmendorf, Director, CBO, letter to Charles Grassley, Ranking Member, Committee on Finance, US Senate, September 22, 2009, http://www.cbo.gov/ftpdocs/106xx/doc10619/09-22-GrassleyLtr.pdf.

[30] For example, the US Department of Health and Human Services estimates that every dollar spent on immunizations generates $27 in future savings; see US Department of Health and Human Services, *HHS Fact Sheet: The Childhood Immunization Initiative* (Washington, DC: US Department of Health and Human Services, 2000), http://www.hhs.gov/news/press/2000pres/20000706a.html. At the same time, the savings from preventative care are partly offset by the cost of screening healthy workers and by increased life expectancy; see Douglas W. Elmendorf, Director, CBO, letter to Nathan Deal, Ranking Member, Subcommittee on Health, Committee on Energy and Commerce, US House of Representatives, August 7, 2009, http://www.cbo.gov/ftpdocs/104xx/doc10492/08-07-Prevention.pdf. In general, primary and secondary forms of preventive care, focused on disease prevention and early detection are far more cost-effective than tertiary preventive care, focused on reduction of existing disease; see Jeffrey Levi, Laura Segal, and Chrissie Juliano, *Prevention for a Healthier America: Investments in Disease Prevention Yield Significant Savings, Stronger Communities* (Washington, DC: Trust for America's Health, 2009) http://healthyamericans.org/reports/prevention08/Prevention08.pdf; and Michael Maciosek, Ashley Coffield, Nichol Edwards, Thomas Flottemesch, Michael Goodman, and Leif Solberg, "Priorities Among Effective Clinical Preventive Services: Results of a Systematic Review and Analysis," *American Journal of Preventive Medicine* 31, no. 1 (2006): 52-61, http://www.ajpm-online.net/article/PIIS0749379706001243/fulltext.

poverty formula based on income and the number of people in the family. For example the 2009 poverty level for a family of four is $22,050, but the poverty level for a family of two is only $14,750. The Senate Finance Committee's proposal would change the formula by not including unauthorized immigrants when determining the size of a household, though their income still would be counted. Many families that would be eligible for benefits under the existing counting rule would appear too wealthy to qualify for benefits if some family members are excluded from the calculation. For instance, a family of four with two unauthorized immigrant parents and two US-citizen children would be eligible for insurance subsidies up to a household income of $88,200 under some proposals (400% of FPL for a family of four) if all family members are counted, but only eligible below an income of $59,000 (400% of FPL for a family of two) under the Finance Committee's proposed change to the formula.[31]

We estimate that 1.2 million US-citizen children have unauthorized immigrant parents and incomes between 150 and 400 percent of FPL — the range for which subsidies could apply in some of the proposals.[32] If the poverty calculation rule proposed in the Senate Finance Committee bill applied only to subsidies, many of these children could be shifted out of private insurance policies and into Medicaid or CHIP. On the other hand, this proposal also could set a precedent for — and be adopted by — the Medicaid and CHIP programs, in which case many of these citizen children with unauthorized immigrant parents could lose coverage altogether.

B. Access to Insurance Exchanges

A separate set of eligibility questions concerns who may purchase *unsubsidized private insurance* through new health insurance exchanges.[33] Existing proposals would allow all LPRs to make purchases through health insurance exchanges. But some members of Congress and the Obama administration have proposed excluding unauthorized immigrants from exchanges.

Very few unauthorized immigrants currently purchase their own insurance because 80 percent of them have incomes below 400 percent of FPL, pricing them out of most private plans. Only about **362,000** unauthorized immigrants purchase private coverage, compared with **6.6 million** who are uninsured and **3.2 million** who obtain coverage through their employers. If the exchanges reduce the cost of private insurance by about 3-14 percent, as

[31] The reduction in the eligibility threshold would vary, of course, by the ratio of unauthorized immigrant members to all family members. For detailed information on FPL calculations see US Department of Health and Human Services, "The 2009 HHS Poverty Guidelines: One Version of the [US] Federal Poverty Measure," http://aspe.hhs.gov/POVERTY/09poverty.shtml.

[32] An estimated 1 million US-born children with unauthorized immigrant parents have incomes between 150 and 300 percent of FPL.

[33] All of the proposals under consideration in this report would establish one or more health insurance "exchanges" or "gateways" through which individuals and small business could purchase insurance. Modeled on the state of Massachusetts' insurance "Connector," the exchanges would make insurance more affordable by providing consumers with information about competing plans and would create a mechanism through which individuals without employer coverage could access private plans.

one estimate projects,[34] allowing unauthorized immigrants to purchase their own insurance through the exchanges could significantly expand coverage within this population.

On the other hand, adding a screening mechanism to exclude unauthorized immigrants from the exchanges would increase administrative costs and create bureaucratic hurdles for the US citizens and legal immigrants using the exchanges, all of whom would also have to be screened.

In the case of unsubsidized purchases through the exchanges, these added screening costs would not save the government any money. While programs such as Medicaid and insurance subsidies cost more with each additional person claiming benefits, the cost of providing information and administering exchanges is not affected by how many people access them.

Preventing unauthorized immigrants from purchasing private coverage through exchanges could also raise long-term health care costs as well as insurance costs for other Americans. Uninsured immigrants would rely on emergency rooms for non-urgent care at higher rates than if they had insurance. They would also avoid preventive care and postpone detection and treatment of chronic conditions, potentially raising the long-term costs of their health care. Moreover, unauthorized immigrants are relatively young and healthy, and if they were included in the risk pool as part of the exchanges, it would like lead to further reductions in premiums for legal immigrants and US citizens.

C. Scope of Employer and Individual Mandates

Proposed health care reforms include a combination of employer and individual mandates. The proposals would establish "pay-or-play" systems through which most employers would be required to offer coverage to their employees or pay a tax penalty, and would impose tax penalties on individuals who fail to carry insurance.

We assume employer mandates will be "status blind" to avoid incentives for employing unauthorized workers, as employers might prefer unauthorized workers over legal immigrants or citizens if they were not required to pay for their insurance.

Status-blind employer mandates have the potential to expand significantly the coverage of immigrants. About **900,000** LPR workers do not now have health insurance, but work at firms that would be covered by proposed employer mandates, assuming they apply to firms with 25 or more employees. More than 1 million LPR workers and their dependents could benefit from employer mandates. And about **1.8 million** uninsured unauthorized immigrants work at firms to which mandates would apply.[35]

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[34] Cathy Schoen, Karen Davis, Stuart Guterman, and Kristof Stremikis, *Fork in the Road: Alternative Paths to a High Performance U.S. Health System* (New York, NY: The Commonwealth Fund, 2009), http://www.commonwealthfund.org/Content/Publications/Fund-Reports/2009/Jun/Fork-in-the-Road.aspx.

[35] The numbers benefitting from employer mandates would, of course, be smaller if the firm size threshold were higher than 25 employees. If the minimum firm size for the employer mandate were 100 employees, it

However, many immigrants work at firms that would be exempt from these mandates. About **1.2 million** LPRs without health insurance are employed by firms likely to be exempt (i.e., firms with fewer than 25 employees), and could be subject to individual mandates. Thus, more uninsured LPRs work for small firms that may be exempt from the mandates than for larger firms to which mandates are likely to apply. An estimated **400,000** LPRs without insurance work at small firms and are subject to the five-year waiting period, meaning they might not be eligible for Medicaid or insurance subsidies.

In addition, **2.3 million** unauthorized immigrants without insurance work at small firms which may be exempt from mandates; these immigrants will certainly be ineligible for Medicaid or subsidies.

The scope of individual mandates remains an open question: would low- and moderate-income immigrants be penalized for not purchasing insurance even if they are barred from Medicaid and insurance subsidies?

In general, expanding the scope of mandates to include recent LPRs and even unauthorized immigrants would save the federal government money, because mandates require people to either purchase health insurance — instead of accessing public systems — or pay a fine. Conversely, excluding immigrants from individual mandates would encourage some individuals to forego health insurance, pushing some people into emergency rooms and other publicly funded programs.

Yet individual mandates will only result in increased coverage if compliance is high. Low-income immigrants, like US citizens, will continue to have difficulties obtaining insurance if they do not have access to Medicaid, insurance subsidies, and/or the lower-cost policies provided though the exchanges. Thus, it would be unrealistic to apply individual mandates to any group of low-income immigrants excluded from Medicaid and insurance subsidies.

D. Verification Requirements

Eligibility for subsidies and access to exchanges raise practical questions about how to implement immigration-status restrictions. How will restrictions on eligibility for health insurance programs be enforced? Who will conduct eligibility screening? Early reform proposals left it to the commissioner of a future insurance program to develop a screening system, but some members of Congress have questioned whether screening would be effective, with some calling for tough and explicit verification requirements.

Verification would be challenging because the United States lacks a reliable document-based identification system, and many US citizens are unable to prove their identity and citizenship.[36] Further, even when an individual's identity can be established, the federal

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would only apply to firms employing 600,000 LPRs and 1.1 million unauthorized workers who are currently uninsured.

[36] The Brennan Center for Justice estimated that 21million US *citizens* lacked valid identity documents in 2006, and 13 million did not have access to passports, birth certificates, or naturalization papers needed to

government lacks a simple and reliable electronic system for verifying citizenship or immigration status. As a result, any requirement that a new health care system screen out unauthorized immigrants or recent LPRs will inadvertently exclude or delay coverage for some US citizens and qualified noncitizens. Screening also will entail higher administrative costs.

Contrary to popular perceptions, there is little evidence that many unauthorized immigrants seek access to Medicaid or other federal benefits for which they are ineligible, in part because they may be reluctant to expose themselves to possible enforcement by fraudulently seeking benefits. A review by Centers for Medicare and Medicaid Services Administrator Mark McClellan of a 2005 report by the Inspector General of the Department of Health and Human Services found that: "The report does not find particular problems regarding false allegations of citizenship [in the Medicaid program], nor are we aware of any."[37] A study of six states by the House Committee on Oversight and Government Reform found evidence of only *eight* unauthorized immigrants who had enrolled in Medicaid.[38] In these six states, for every $100 spent on the Medicaid documentation requirements authorized by the 2005 Deficit Reduction Act (DRA), the federal government saved only 14 cents as a result of denying coverage to unauthorized immigrants.[39] And a survey of 44 states by the Government Accountability Office (GAO) found that only one state reported savings as a result of unauthorized immigrants who were screened out by changes in Medicaid documentation standards.[40]

Two general verification models have been proposed for new health insurance systems: the Secure Alien Verification for Entitlements (SAVE) program model and tax-based screening, as employed by the Earned Income Tax Credit (EITC) program.

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prove their citizenship. See Brennan Center for Justice at NYU School of Law, *Citizens without Proof: A Survey of Americans' Possession of Documentary Proof of Citizenship and Photo Identification* (New York, NY: New York University, November 2006), http://www.brennancenter.org/page/-/d/download_file_39242.pdf. Most LPRs, however, possess reliable identification document in the form of green cards (I-551s) which are considered proof of identity and legal status, and are more fraud-resistant than most driver's licenses.

[37] US Department of Health and Human Services, Office of Inspector General, "Self-Declaration of U.S. Citizenship for Medicaid (OEI-02-03-00190)" (Washington, DC: US Department of Health and Human Services, July 2005), 27, http://oig.hhs.gov/oei/reports/oei-02-03-00190.pdf. Also see Center on Budget and Policy Priorities, *Charge that Bipartisan SCHIP Compromise Bill Aids Undocumented Immigrants is False* (Washington, DC: Center on Budget and Policy Priorities, 2007), http://www.centeronbudget.org/cms/index.cfm?fa=view&id=680.

[38] Majority Staff Committee on Oversight and Government Reform, Rep. Henry A. Waxman, Chairman, "Summary of GAO and Staff Findings: Medicaid Citizenship Documentation Requirements Deny Coverage to Citizens and Cost Taxpayers Millions," http://oversight.house.gov/documents/20070724110341.pdf.

[39] See House Committee on Oversight and Government Reform, "Summary of GAO and Staff Findings: Medicaid Citizenship Documentation Requirements Deny Coverage to Citizens and Cost Taxpayers Millions," http://oversight.house.gov/documents/20070724110341.pdf.

[40] US Government Accountability Office, *Medicaid: States Reported Citizenship Documentation Requirement Resulted in Enrollment Declines for Eligible Citizens and Posed Administrative Burdens*, GAO-07-889 (Washington, DC: Government Accountability Office, 2007), http://www.gao.gov/new.items/d07889.pdf.

SAVE

The SAVE program was established in 1987 to allow government agents to screen immigrants' eligibility for public benefits such as Medicaid and CHIP. SAVE allows screeners to verify an immigrant's status by comparing her name, Social Security number (SSN), and Alien identification number to information in DHS databases. In the case of an individual claiming US citizenship, government screeners may also use the Social Security Number Verification System (SSNVS) to confirm that the person's name and SSN match information in the Social Security Administration (SSA) database. These systems are relatively complex, and state Medicaid agents must be trained to use them and must follow specific guidelines designed to protect the privacy of system users and to prevent errors.

The main advantage of systems like SAVE is that they permit relatively sophisticated screening rules. In the case of Medicaid, for example, screeners verify not only legal status, but also whether LPRs fall within the five-year waiting period.

Individual screening also permits program staff to review applicants' identity documents to protect further against fraudulent claims. The 2005 DRA tightened identification requirements for US citizens to prevent unauthorized immigrants from fraudulently obtaining Medicaid, though few were screened out as a result, as noted above. Instead of attesting to their name and citizenship, citizens were required to present birth certificates, passports, or other documents to prove their identity and eligibility in order to obtain coverage.

The SAVE model has two disadvantages for health insurance screening. First, requiring individual screening before providing insurance benefits would increase the administrative expense of any health insurance system, especially if screening were to include document checks. Illinois planned to spend $16 to $19 million to train and employ additional verification staff to comply with the 2005 DRA, for example.[41] The GAO study found that all 44 states surveyed took new administrative measures to comply with the DRA, including hiring additional staff and providing new training. For the ten states in the study providing data, new appropriations ranged from $350,000 to $10 million per state, or 1-12 percent of previous Medicaid administrative expenditures, for a total of $28 million.[42] If verification of eligibility for subsidies and health exchanges generated similar costs, it could add several percent to the administrative costs of health care reform — an investment that may offer low returns given how few unauthorized immigrants were found to have been denied Medicaid as a result of the DRA requirements.

Second, screening through a SAVE-style system can produce false nonconfirmations — that is, eligible US citizens and LPRs may be wrongly denied coverage or face coverage delays — unless adequate due-process protections are in place. Significant false nonconfirmation problems are especially likely to emerge when documentary proof of US citizenship is required, as was the case in the Medicaid program following DRA implementation, because

[41] Donna Cohen Ross, "New Medicaid Citizenship Documentation Requirement Is Taking a Toll" (Washington, DC: Center on Budget and Policy Priorities, March 2007), http://www.cbpp.org/files/2-2-07health.pdf.

[42] GAO, *Medicaid: States Reported that Citizenship Documentation Requirement Resulted in Enrollment Declines for Eligible Citizens and Posed Administrative Burdens,* 20.

millions of US citizens do not have valid government-issued identification. Tens of thousands of otherwise eligible US citizens were unable to meet the DRA Medicaid identification requirements or faced significant delays in coverage after the law went into effect in 2007.[43] Documented errors in the underlying databases used by SAVE and SSNVS also likely cause some US citizens and eligible LPRs to be wrongly denied benefits or to face verification delays.[44]

Lawmakers could limit the impact of false nonconfirmations by including provisions in health reform similar to those in the 2009 Children's Health Insurance Program Reauthorization Act (CHIPRA), which required that states provide Medicaid benefits to otherwise eligible individuals for a reasonable period of time while they obtain their documents or sort out database errors. Erroneous nonconfirmations in SAVE and the SSNVS also could be reduced by permitting individuals to view and correct their own records and by providing citizens and eligible LPRs with clearer instructions about how to correct erroneous nonconfirmations when they occur.

The Tax System and EITC

One alternative to "front-end" verification would be to provide insurance subsidies by reimbursing eligible people through their tax returns. In this case, individuals and families would report health insurance premiums on their tax forms, and moderate-income taxpayers would be eligible for a tax reduction or refund equal to the amount of the subsidy they are owed. The Internal Revenue Service (IRS) would limit payments to individuals and family members with valid SSNs. This system is already employed to ensure that unauthorized immigrants do not receive EITC refunds.[45]

The main advantage of a tax-based screening system is that it would be simpler and less costly to implement because it would not substantially expand existing screening staff. Because almost all unauthorized immigrants lack valid SSNs, their tax returns would not

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[43] According to GAO, half of all states surveyed reported declines in Medicaid coverage as a result of the new ID requirements, and "a majority of these states attributed the declines to delays in or losses of Medicaid coverage for individuals who appeared to be eligible citizens." Only a few states were able to quantify these effects, but one state reported that 18,000 people were denied or lost coverage due to the ID requirements even though the state believed them to be eligible citizens. (In order to promote participation in its survey, GAO does not identify states by name in its report.) See GAO, *Medicaid: States Reported that Citizenship Documentation Requirement Resulted in Enrollment Declines for Eligible Citizens and Posed Administrative Burdens*, 4-5. Also see Donna Cohen Ross, *Medicaid Documentation Requirement Disproportionately Harms Non-Hispanics, New State Data Show* (Washington, DC: Center on Budget and Policy Priorities, 2007), http://www.cbpp.org/cms/index.cfm?fa=view&id=471.

[44] Error rates in the E-Verify program, used by employers to confirm the work eligibility of newly hired workers, offer some insight into SAVE error rates since the systems rely on the same SSA and DHS databases. In previous research we estimated the false nonconfirmation rate in E-Verify at about 1 percent, but some employers have reported much higher error rates — up to about 12 percent. Error rates may differ in the SAVE program since is it administered by government screeners, rather than private employers, and because E-Verify is a mostly voluntary program, used by a small nonrepresentative sample of employers. See Doris Meissner and Marc Rosenblum, *The Next Generation of E-Verify Getting Employment Verification Right* (Washington, DC: Migration Policy Institute, 2009), http://www.migrationpolicy.org/pubs/Verification_paper-071709.pdf.

[45] For a more complete discussion of EITC screening see Francine Lipman, "Taxing Undocumented Immigrants: Separate, Unequal and Without Representation," *Tax Lawyer* 59, no. 3 (2006), http://papers.ssrn.com/sol3/papers.cfm?abstract_id=881584.

match information for citizens and legal immigrants in the SSA database, and most automatically would be denied reimbursement.[46]

An EITC-style screening system would be limited in three respects. First, while the system should screen out unauthorized immigrants, it cannot distinguish between recent LPRs and those outside the five-year waiting period, because all LPRs may obtain SSNs.

Second, because an EITC-style system would be based on reimbursing health insurance spending, its use would be limited to subsidies paid in the form of tax credits. EITC-style screening could not be used to prevent unauthorized immigrants from purchasing their own unsubsidized insurance through health insurance exchanges or directly from insurance providers, for example.

Third, erroneous denials under an EITC-style system could also cause substantial hardship as potential beneficiaries would have paid their premiums before they were denied the tax credits.

E. Designing Eligibility Verification for Health Insurance Reform

Lawmakers may consider one or the other — or both — of these screening options for each of the four elements of the health insurance system affected by reform:

- **Eligibility screening for Medicaid.** Federal Medicaid law already requires government agents to screen Medicaid applicants for eligibility based on immigration status, among other criteria. As noted above, the 2005 DRA resulted in verification problems for many US citizens, but the 2009 CHIPRA partly addressed these problems by requiring that states provide Medicaid benefits to otherwise eligible individuals for a reasonable period of time while they obtain their documents.[47]

- **Eligibility screening for insurance subsidies**. Lawmakers almost certainly will require that unauthorized immigrants be denied insurance subsidies, and they must decide whether or not recent LPRs also would be ineligible. Screening for eligibility could consist of a SAVE-style screening system, an EITC-style system, or a combination of the two. Either system could identify unauthorized immigrants, but only a SAVE-style system could identify recent legal immigrants. A SAVE-style system would be more costly, especially if combined with document checks. As in the Medicaid program, document checks and false non-confirmations could inadvertently screen out many eligible citizens and LPRs.

- **Eligibility screening for unsubsidized purchases through health insurance exchanges**. Lawmakers and the Obama administration have proposed preventing unauthorized immigrants from purchasing private, unsubsidized insurance though

[46] Many unauthorized immigrants have an Individual Taxpayer Identification Number (ITIN), which they may use to pay income or payroll taxes.
[47] The "hold-harmless" period required by CHIPRA is, in rare instances, not long enough for applicants to obtain needed documents such as birth certificates.

health insurance exchanges. To screen out unauthorized immigrants from this system would require that a new government bureaucracy — or 50 new bureaucracies for state-level exchanges — be established and staff trained to use a SAVE-style system. The new systems also would need to incorporate an appeals process for citizens wrongly excluded from the exchange.

- **Eligibility screening by private employers or insurance providers outside the health insurance exchanges**. Some lawmakers have also proposed requiring that employers and/or insurance providers use the E-Verify system to screen their employees or customers for eligibility based on immigration status prior to providing health insurance. E-Verify is a national database that employers can use to check the work eligibility of immigrants against the DHS and SSA databases. It is currently voluntary for most employers, but a federal requirement that government contractors check the work authorization of new employees recently went into effect, and a handful of states require that all businesses verify work authorization of new hires. As of July 2009, about 140,000 out of 7.4 million US employers used E-Verify to check the lawful status of their new employees, so rapid scaling-up of the system could present challenges.

  Eligibility screening for private insurance based on immigration status would represent a significant new restriction on private insurance markets. It would also represent a substantial expansion of the E-Verify system — something Congress has considered and rejected in the context of immigration policy. To require employers or private insurers to screen the families of employees or customers would represent an even sharper departure from the status quo, one that could affect the coverage of many of the 3.4 million US-born citizen children with unauthorized parents. Such a screening requirement would impose new costs on employers and/or insurance providers, costs that would likely would be passed on to US citizens and legal immigrants in the form of higher insurance premiums.[48] Employer or provider screening would also result in some citizens and legal immigrants wrongly being denied coverage due to system errors or employer mistakes. Screening by private providers also raises privacy concerns and could result in increased identity theft, a problem that already affects about 10 million Americans a year.[49]

[48] Employers surveyed by WESTAT in its congressionally-mandated review of E-Verify expressed a high degree of satisfaction with the program; see Westat, *Findings of the Web Basic Pilot Evaluation* (Rockville, MD: Westat, 2007), http://www.uscis.gov/files/article/WebBasicPilotRprtSept2007.pdf. Business groups have argued that administrative costs run as high as $27,000 to $40,000 per year; see American Council on International Personnel, "Comments on Proposed Rule Published at 73 Fed. Reg. 33374 (June 12, 2008)," August 11, 2008; and US Chamber of Commerce, "Comments on Proposed Rule to Require Federal Contractors to Participate in the Basic Pilot/E-Verify Program Published at Federal Acquisition Regulation ("FAR") Case 2007-013, August 11, 2008, http://www.uschamber.com/NR/rdonlyres/e2jcsmosmq42mivhoipn2nnxpz6tjqk3sr66pbdnqeqfzr4t2ul5nifsxaslehiu57ir4tpt3shi355dwhlrt2jvhcd/USCCCommentsonFedKsEVerifyRequirement.pdf.

[49] Javelin Strategy and Research estimates that costs of identity fraud to US victims were $48 billion in 2008. See Rachel Kim, *2009 Identity Fraud Survey Report* (Pleasanton, CA: Javelin Strategy and Research, 2009), http://www.javelinstrategy.com/products/A87547/127/delivery.pdf.

IV. Conclusion

Health insurance reform has the potential to expand the coverage of millions of legal immigrants through Medicaid expansion, private insurance subsidies, and mandated employer coverage. But the breadth and cost of reform will be substantially affected by the decisions lawmakers make about eligibility for recent LPRs, and approaches to screening out unauthorized immigrants. Policies that exclude recent LPRs from Medicaid or insurance subsidies would leave a large number of people uninsured, especially in large immigrant states like California, New York, Texas, and Florida. These states would also be hard-hit by policies that push unauthorized immigrants out of the employer-based coverage many now have. Immigrants who become or remain uninsured still will require costly treatment in emergency rooms, clinics, and other settings, with much of the costs borne by state and local governments — and ultimately by taxpayers and health care consumers.

Reform also will need to strike the right balance on verification requirements. In the case of subsidies that are paid through tax credits, checking Social Security numbers on tax returns, as is done in EITC, has proven to be a comparatively inexpensive and effective way to screen out unauthorized immigrants. At the same time, recent experience shows that verification approaches requiring applicants to provide documents like birth certificates that prove their legal status can deny or delay benefits for vulnerable citizens. Finally, any new requirement for screening by employers or insurance providers would represent a sharp departure from existing law, and could impose significant costs on businesses, raise the cost of insurance for all Americans, and reduce coverage for some citizens and immigrants.

In the cases of both the 1996 Welfare Reform Act and the 2005 Deficit Reduction Act, we have seen Congress impose tough new rules that have had unintended negative impacts on both citizens and noncitizens, have shifted costs to state and local governments, and have had to be revisited and rectified in new legislation. Despite the heated political debate, health care reform offers an opportunity to get eligibility and verification right — one that should not be missed.

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