IMPROVING IMMIGRANT ACCESS TO AFFORDABLE HEALTH COVERAGE
Analysis of the Massachusetts Health Care System as a Model

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As the national debate over health care reform intensifies, many have pointed to Massachusetts as a model for federal health care reform legislation. This discussion paper addresses key aspects of the Massachusetts system — some of which derived from the state's major 2006 health reform legislation, but much of which is rooted in longer-standing policy — that has made it a leader among states in providing affordable heath care to low-income immigrants. Although Massachusetts therefore serves as a promising model for how federal health care reform can address the needs of immigrants, improvements to the Massachusetts model are also needed: Too many individuals continue to lack access to affordable care in Massachusetts, and a disproportionate share of the uninsured continue to be immigrants, due primarily to remaining exclusionary rules in insurance programs.

This paper is based on reports assessing the early results from implementation of the 2006 reform, as well as important input provided by the Massachusetts Law Reform Institute and the Massachusetts Immigrant and Refugee Advocacy Coalition. It focuses on major policy decisions undertaken before and after the 2006 reform in Massachusetts and does not attempt to cover the wider range of barriers immigrants face when seeking to secure health care (e.g., verification obstacles, concerns regarding public charge, language access).

■ Features that Preexisted the 2006 Reform

National health reform is an opportunity to rectify the damage wrought by discredited provisions of the 1996 welfare law imposing harsh and unprecedented restrictions on immigrant eligibility for public health coverage. Like many other states, Massachusetts has chosen, at state expense, to provide health coverage to a range of immigrants ineligible for federally funded assistance. In many cases, the 2006 Massachusetts reform simply preserved the underlying framework of favorable state rules. Reforms to immigrant exclusions under federal law are necessary to reverse an unfair cost shift with which Massachusetts and other states are struggling, particularly in the current environment of state fiscal crises.

Public Coverage for Lawfully Residing Immigrants, with No Five-Year Waiting Period

The 1996 welfare law foreclosed federally funded health coverage to immigrants who do not fall within one of the small number of "qualified alien" categories enumerated in that law. This excludes a range of immigrants who are lawfully residing in the U.S. Following the 1996 law, Massachusetts preserved eligibility for health coverage (through use of state-only funds) for individuals who are "permanently residing under color of law"(PRUCOL), such as a spouse or child of a U.S. citizen whose application for adjustment of status is pending with U.S. Citizenship and Immigration Services (CIS). The dividing line between "qualified" immigrants and other lawfully residing immigrants holds little salience in terms of public opinion.

- The "lawfully residing" standard used in the Legal Immigrant Children's Health Improvement Act (ICHIA), enacted as Section 214 of the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA), has precedence in the food stamps and Social Security rules. It is more inclusive and meaningful to the public than the more limited "qualified" immigrant definition, though it falls short of providing the comprehensive health coverage system the nation needs.

Massachusetts also rejected the five-year waiting period arbitrarily imposed by the 1996 welfare law;

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the state has long covered immigrants permanently residing under color of law regardless of how long they had been living in the U.S. Research shows that immigrants' earnings and jobs improve significantly over time. The five-year bar hits most immigrants at the worst, and most inappropriate time, during their initial period in the U.S. when they are least likely to have jobs that offer employer-sponsored coverage or be able to afford private coverage. Covering immigrants during this crucial time will provide them with a healthy foundation from which to improve their economic and professional standing, thereby increasing the likelihood that newcomers will have access to employer-sponsored insurance.

- Voters do not understand why our country makes legal immigrants wait five years before their eligibility for health coverage programs is considered; a recent poll conducted for First Focus underscores the strength of public support for eliminating the five-year bar. Senator Max Baucus's (D-MT) white paper signaled support for addressing the issue as part of health care reform. The time is right to eliminate the five-year waiting period as matter of mandatory national policy. States should not be given the option to discriminate against lawfully residing immigrants.

Massachusetts's 2006 legislation maintained coverage for PRUCOLs in the newly created Commonwealth Care without imposition of any waiting period and preserved their eligibility in state-funded programs such as the Children's Medical Security Plan (CMSP) and the state-funded components of MassHealth Essential and MassHealth Family Assistance (these various programs are described below).

- Federal health reform provides an opportunity to integrate immigrants fully into federally funded coverage programs, sparing states like Massachusetts from the administrative complexities, fiscal costs, and marketing challenges involved in setting up separate, exclusively state-funded programs in this manner.

Coverage for Immigrant Children Regardless of Immigration Status

There is strong public support for ensuring that all children have access to affordable health coverage, and for much of the public, this support does not appear to depend on the child's immigration status. CMSP provides primary and preventive medical and dental coverage to uninsured children who are Massachusetts residents but who do not qualify for MassHealth, including immigrant children who do not qualify for MassHealth due to immigration status. Massachusetts' 2006 legislation maintained CMSP as a distinct program rather than rolling all children into a single, streamlined system. (Immigrant children who are subject to the five-year bar or PRUCOL are eligible for the more comprehensive benefits of the Family Assistance program, the same benefits available under Massachusetts' Children's Health Insurance Program (CHIP), but at state-only expense). While much better than some states, in which undocumented and other federally ineligible immigrants have access to no public coverage, CMSP does not satisfy the goal of guaranteeing affordable and comprehensive health coverage for all children. Its enrollment and benefits are capped, and its scope of coverage is limited.

- The approach taken in Illinois provides a better example. Its unified *AllKids* program is literally open to all children — of any immigration status, as well as of any family income level (copayments apply depending on income).

Prenatal Coverage for Pregnant Women Regardless of Immigration Status

Massachusetts, like a dozen other states, has opted to use CHIP funds to provide pregnancy-related health services to low-income women regardless of immigration status. This option is available under federal regulations from 2002 permitting unborn fetuses to be classified as targeted eligible children beneficiaries of CHIP. Providing health coverage to pregnant women is the most cost-effective form of health coverage; a study in the American Journal of Obstetrics and Gynecology found that every dollar spent on prenatal care for immigrant women saved $3 in care to mother and child soon after birth and $4 in longer-term medical costs.

- To ensure that mothers receive comprehensive prenatal as well as post-partum care, federal health reform should make affordable health coverage available to pregnant women regardless of status, without the need to artificially classify the beneficiary as the unborn child.

Preservation of Safety Net Services for Those Remaining Uninsured

If we truly seek universal coverage with cost-saving for patients and the government, it is necessary to cover all people living in the U.S., including immigrants regardless of status. If categories of the U.S. population are left out of coverage, the government will be forced to compensate hospitals and clinics in the safety net for providing medical care to patients who are not permitted to enroll in affordable health insurance and who cannot possibly pay for costly health care out-of-pocket. In addition, people who cannot afford preventive and primary care forgo treatment until their illnesses are at much more advanced stages, at which point the government will be forced to pay for costlier emergency care. Allowing immigrants to purchase affordable health insurance on the same basis as other Americans will result in billions of additional dollars in insurance premiums being paid by immigrants, whereas excluding immigrants would result in the loss of an enormous revenue stream that can help fund health reform.

One must recognize, however, that federal health care reform, like Massachusetts health reform, may not secure health insurance for 100 percent of the population in one fell swoop. Even if formal rules provide for the potential of universal coverage, challenges to enrollment would inevitably remain.

- The 2006 Massachusetts legislation preserved the Health Safety Net fund that reimburses hospitals and health centers for treating the uninsured without regard to citizenship or immigration status. Barring universal coverage, it will be critical to low-income immigrants and citizens that federal reform preserve and strengthen safety-net hospitals and clinics for the uninsured. Most safety-net providers need additional resources in order to operate, since they rely heavily on Medicaid and Medicare reimbursements that do not fully cover their costs of providing services and can therefore not afford to meet their mandate to care for the uninsured. Government transfers to safety-net providers need to reflect 21st century medical costs, rather than the current system of reimbursing these providers less than the cost of services.

■ New Features Introduced in Massachusetts' 2006 Reform

Promoting Coverage through Employer-Sponsored Plans

Research indicates that immigrants take up employer-sponsored insurance (ESI) if it is offered. However, low-income immigrants work in jobs least likely to offer ESI. Although in concept an employer mandate is a key part of the equation, it is unclear whether Massachusetts' 2006 approach was sufficiently "mandatory" to push many employers to newly offer coverage, and new coverage options for small employers through the state's Health Insurance Connector Authority are still in development.

- Given low-income immigrants' high rates of employment and low rates of ESI coverage, improving access to ESI may be the single most important element in boosting health insurance rates among them and their dependents. Federal reform needs to provide a stronger incentive to employers — whether through bigger sticks (higher "pay" for failure to "play" and a stronger threshold for what fair and reasonable "play" entails), or bigger carrots (such as tax credits and/or subsidies).

No Separate Verification Requirements for ESI; Nondiscrimination Also Needed for Private Coverage

Proposals affecting employer coverage should treat all workers equally, including immigrant workers and their families. Workers must have a level playing field, and employers must not be given an "out" to fulfilling a mandate to providing coverage. Once a worker has already been authorized by an employer to work though the hiring process, the worker should not be subjected to any additional immigration-related verification to obtain ESI.

- Massachusetts' 2006 legislation serves as model for *not* imposing any additional verification screens.

Federal health reform must also prevent private insurers from discriminating, directly or indirectly, against applicants based on immigration status. It is in the public interest to encourage as large a number of residents as possible to obtain health coverage.

Excluding immigrants from the insurance pools increases the burden on all of us.

- As part of a broader set of civil rights and privacy protections, insurers should be prohibited from inquiring into immigration status or from requiring that insurance applicants provide "proxies" for immigration status, such as Social Security numbers.

Subsidized Insurance Coverage for Lower-Income Adults

Massachusetts' legislation established Commonwealth Care, which provides subsidized insurance for low-income adults (up to 300% FPL) who lack ESI and who are ineligible for MassHealth. Any federal reform must devise affordable options for low-income workers who are ineligible for existing public coverage programs. However, Commonwealth Care fails to offer a solution for immigrants who are undocumented or otherwise not PRUCOL, since the program imposes immigration-related restrictions. The 2006 law also provided coverage for elderly and disabled immigrants living below the poverty line, at state-only expense, in MassHealth Essential (coverage for adults who are long-term unemployed and for certain immigrants who do not qualify for MassHealth), but only for those immigrants subject to the five-year bar or PRUCOL. Immigrants with long-term health needs face difficulty getting those needs met under Commonwealth Care and MassHealth Essential: Neither program covers nursing facility care or home health support, which are covered for other low-income persons under Medicaid-funded MassHealth.

- The remaining restrictions in Commonwealth Care and Mass Health Essential go far in explaining why so many immigrants remain uninsured or underinsured in Massachusetts. The obvious solution would be to eliminate distinctions between different groups of immigrants and operate programs developed under federal reforms on the basis of need, continuity, and consistency of care.
- At minimum, subsidies (or participation in public coverage programs) should be available to any worker whose employer failed to provide ESI and paid a resulting penalty. The penalty should fund the alternative coverage program, and, as a matter of basic fairness, any workers left without ESI due to their employers' failure to provide coverage should be entitled to participate in that program.

Affordability as Key Factor in Defining Individual Mandate

In Massachusetts, many low- and moderate-income individuals excluded from public programs or subsidies due to their immigration status are able to avoid paying a penalty under the individual mandate requirements. Having been barred from Commonwealth Care and MassHealth, there are clearly no affordable health insurance options available to them.

- Although affordability should continue to be an essential factor in defining any individual mandate, it is little consolation to low-income immigrants that they are not being subjected the double injury of having to pay a penalty for their lack of access to insurance. The goal should be to establish affordable coverage options rather than exempt individuals from a mandate on affordability grounds.

Eliminating Sponsor-Related Barriers

Proposals that aim to provide health coverage to lawfully residing immigrants must also eliminate artificial barriers that prevent immigrants and their family members from securing this coverage. It thwarts the goals of health reform to assume, for example, that income or coverage is available to a family when it is not, or to threaten family members with lawsuits if an immigrant secures coverage. The automatic "deeming" rules that attribute a sponsor's income to an immigrant regardless of the support actually provided by the sponsor undermine access to care. Indeed any questioning about an immigrant's sponsor often deters eligible immigrants from seeking critical coverage. It is unrealistic to assume that sponsors can find and purchase affordable health insurance for sponsored immigrants and inappropriate to assume that immigrants have such fictional health coverage.

- Massachusetts' 2006 legislation prohibited sponsor-deeming in state-funded programs, setting a strong precedent. Other states have also worked to minimize sponsor-related barriers, and ICHIA includes provisions that address this issue as a matter of federal law. Federal health care reform should conform to reality and con-

sider only the income and resources *actually* available to immigrants when determining eligibility for coverage.

Outreach and Enrollment Initiatives to Reduce Health Disparities

Many Americans have difficulty navigating the health care and insurance maze, and many who want coverage are unable to overcome enrollment hurdles or are churned-out of coverage due to complicated recertification rules. Nonprofit organizations are able to assist many of the most marginalized Americans to learn about their options for affordable health coverage and to connect with insurance. States that are truly committed to optimizing enrollment in health coverage programs have demonstrated that outreach and enrollment assistance significantly increase insurance take-up rates and help to reduce racial and ethnic disparities.

The 2006 Massachusetts legislation led to the creation of an outreach and enrollment unit to minimize disparities in coverage and access, ensuring that information on health reform reaches all residents and advocating for at-risk communities. Outreach and enrollment grants of $3.5 million were provided to community-based organizations across the state to enroll hard-to-reach populations into coverage and help enrollees maintain and retain coverage during any eligibility re-verification process. The Massachusetts law also made reducing disparities a performance benchmark for hospital rate increases and created a Health Disparities Council to recommend other measures to reduce disparities.

- Federal health reform must address the moral imperative to reduce the disparities that exist throughout the health care system and should incorporate the robust set of policies that has been previously envisioned in stand-alone legislation such as the Tri-Caucus's Health Equity and Accountability Act.

■ Core Improvement Needed: *Realize the Promise of Affordable Health Care for All*

Massachusetts' 2006 legislation made a real dent in the problem of uninsurance, the rate of which fell from 13 percent to 7 percent in the first year of implementation alone. Although many immigrants benefited from Massachusetts health reform, immigrants remain disproportionately uninsured, hindering the state from achieving truly universal coverage. Too many low-income Massachusetts residents lack access to affordable coverage. In April 2007, the Connector board reported that it planned to exempt approximately 60,000 people from the individual mandate — almost 20 percent of uninsured adults ineligible for state subsidies — having determined that even the lowest cost insurance would be unaffordable for them. Health reform in Massachusetts did not fundamentally alter the cost of health care; therefore, individuals who have no choice other than private insurance coverage (because they lack employer-sponsored coverage or are not eligible for subsidized care) are left without any viable coverage option. One answer might be more effective pooling of insurance risks — within public, subsidized, ESI, and private insurance programs. Fuller incorporation of immigrants, including undocumented immigrants, who are on average younger and healthier than the general population, is part of the solution.

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