
Revised February 1, 2024

States Are Providing Affordable Health Coverage to People Barred From Certain Health Programs Due to Immigration Status

By Claire Heyison and Shelby Gonzales¹

Health coverage plays a key role in improving people’s health outcomes and quality of life. Unfortunately, many people who are immigrants remain uninsured, largely because of immigration-related restrictions to government health programs. Many states have responded to this challenge by creating affordable health coverage options for people whose immigration status bars them from enrolling in Medicaid, the Children’s Health Insurance Program (CHIP), and the Affordable Care Act (ACA) marketplace. The experiences and successes in these states provide a useful roadmap for advocates and policymakers aiming to ensure that all people in the U.S. have access to affordable health coverage.

Everyone should have access to affordable health coverage and the chance for well-being that it provides. That includes people who are immigrants, who make profound contributions to our country and communities. But people who are immigrants often can’t or don’t access health coverage and services because they are systematically shut out of government health programs or they fear they will be penalized if they access programs for which they are eligible, due to confusing and fluctuating immigration policies.²

Restrictions that keep people without a documented immigration status out of Medicare and Medicaid date back to the 1960s and 1970s, while restrictions on a host of people with lawful immigration statuses came much later, in the 1990s. The nation’s immigration laws — which make lawful immigration very difficult — have caused many people who are immigrants to delay health care or avoid government programs for fear of immigration enforcement. In addition, the negative treatment of both people with and without a documented immigration status in health and

¹ The authors thank Kiran Rachamalla, who contributed to the research and fact-checking for this report.

² Nambi Ndugga and Samantha Artiga, “Disparities in Health and Health Care: 5 Key Questions and Answers,” KFF, April 21, 2023, <https://www.kff.org/racial-equity-and-health-policy/issue-brief/disparities-in-health-and-health-care-5-key-questions-and-answers/>.

economic security programs further marginalizes people who are immigrants as they seek to meet their basic needs.

The results of this exclusionary approach are harrowing. Often, people with kidney failure wait until near death to get dialysis, older adults' health deteriorates due to preventable illnesses, and pregnant people avoid prenatal care because they fear enrolling in government programs.³ But these results are also preventable. While federal action is needed to ensure universal coverage and promote the health and well-being of all people in our nation, states are taking action to boost access to medical care and health coverage, improve health, and save lives by expanding eligibility for health insurance to people who are immigrants.

This paper describes how states have used limited federal options as well as innovative state-led initiatives to expand coverage. We begin with an overview of the eligibility restrictions in place for people who are immigrants and of the impacts of going without coverage. We then describe how states can receive federal matching funds to broaden Medicaid and CHIP eligibility for some children and pregnant people when they would otherwise be barred from these programs because of their immigration status. These coverage expansion options are partially funded by the federal government and can be implemented relatively quickly; however, their scope is limited to children and pregnant people, and federal funds cannot be used for coverage of children without a documented immigration status.

Next, we describe two paths states are taking to design their own programs for people who are immigrants who are ineligible for other types of health coverage. The first is through Medicaid look-alike programs, which are available in 5 states and the District of Columbia. Most of these states target help to children, and some also cover people who are pregnant, people after pregnancy, older adults, or all adults. And most of these programs offer free, comprehensive coverage similar to Medicaid to people whose immigration status leaves them ineligible for that program.

FIGURE 1

States Have Options to Remove Immigration-Related Barriers to Health Coverage

Federal law bars many people who are immigrants from affordable health coverage programs, worsening health and economic outcomes.

What can states do?

Adopt Medicaid and CHIP options that cover people otherwise barred due to their immigration status:

- ✓ The “**lawfully residing**” options for children and pregnant people, allowing states to use less restrictive immigration-related eligibility requirements
- ✓ The **from conception-to-end-of-pregnancy (FCEP) CHIP option** and **CHIP Health Services Initiatives (HSIs)**, which provide coverage during pregnancy and the post-pregnancy period for people who don't meet Medicaid's immigration-related standards

Enact state-led initiatives that provide health coverage to people ineligible for Medicaid, CHIP, and ACA marketplace coverage due to their immigration status:

- ✓ Create **Medicaid look-alike programs**, which can offer free, comprehensive coverage
- ✓ **Make ACA-compliant individual health plans accessible and affordable** to people who don't meet the ACA marketplace immigration-related requirement

Implement all programs in a way that maximizes participation among those eligible:

- ✓ Ensure applications are designed to allow people who are immigrants, or in families that include immigrants, to feel safe applying

Note: CHIP = Children's Health Insurance Program. ACA = Affordable Care Act.

For more information, see “States Are Providing Affordable Health Coverage to People Barred From Certain Health Programs Due to Immigration Status”

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³ Nathan A. Gray, “Cruel Carousel: The Grim Grind of ‘Compassionate’ Dialysis,” *JAMA Journal of Ethics*, August 2018, <https://journalofethics.ama-assn.org/article/cruel-carousel-grim-grind-compassionate-dialysis/2018-08>; UC Riverside Center for Social Innovation, “The Health Needs of Undocumented Older Adults: A View on Health Status, Access to Care, and

The second approach is to provide access to affordable, ACA-compliant health plans for people ineligible for ACA marketplace coverage and federal premium assistance because of their immigration status. For example, Colorado requires insurers that sell plans through the state's ACA marketplace to also offer health plans on a separate platform, where people who are ineligible for marketplace plans for non-financial reasons can enroll in marketplace-like coverage. Washington State is using a Section 1332 waiver to allow people ineligible for Medicaid, CHIP, and ACA marketplace coverage to enroll in the state's marketplace. Both states have allocated funding to lower the cost of marketplace plan premiums for people with low and moderate incomes, regardless of their immigration status.

But however innovative these approaches can be, funding constraints can limit their scope, and fears that receiving health coverage could have negative immigration consequences can limit their effect. States can lessen the effect of such constraints and improve the reach of their programs by taking into account certain operational and logistical considerations — the subject of this report's final section. For instance, pre-registering people for Medicaid payment of emergency services and assuring them that their personal information will not be shared offer peace of mind and encourage people to access care.

Funding opportunities for these programs are highlighted in text boxes throughout this report. For example, many states have designed their programs with the awareness that the federal Medicaid program reimburses health care providers for the treatment of emergency medical conditions experienced by people who meet all requirements for their state's Medicaid program except for the immigration-related eligibility standard. Some states have chosen to exclude treatment for emergency services from health insurance programs that serve people whose medical emergencies can be covered by Medicaid payment for those services. Other states pay for emergency services for people who meet all requirements for Medicaid except for the immigration-related eligibility standard and work with the federal government to utilize Medicaid payment for emergency services to reimburse the state for these costs.

Altogether these state approaches can go a long way toward ensuring equitable access to health coverage. Federal action is needed to achieve universal coverage in this country, and bills like the Health Equity and Access under the Law (HEAL) for Immigrant Families Act and the Lifting Immigrant Families Through Benefits Access Restoration (LIFT the BAR) Act — which would expand access to economic and health security programs to more people with various immigration statuses — are a good start. But in the meantime, states should be doing their utmost to ensure people who are immigrants can access the care they need to stay healthy and thrive.

Federal Law Bars Many People Who Are Immigrants From Affordable Health Coverage Programs

The ACA's expansion of Medicaid, creation of individual marketplace coverage with financial assistance, and other measures dramatically increased U.S. insurance rates and helped shrink racial

Barriers," July 2019, <https://socialinnovation.ucr.edu/health-needs-undocumented-older-adults-view-health-status-access-care-and-barriers>; Caitlin Dickerson, "Undocumented and Pregnant: Why Women Are Afraid to Get Prenatal Care," *New York Times*, updated July 9, 2021, <https://www.nytimes.com/2020/11/22/us/undocumented-immigrants-pregnant-prenatal.html>.

and ethnic disparities in coverage.⁴ But significant inequities persist,⁵ and racist immigration-related policies play a key role.

When Medicaid was created in 1965, the legislation required states to cover all individuals within the program's mandatory coverage groups (which included families with children receiving cash assistance, older adults, and people with disabilities) without reference to citizenship or immigration status. Initially, most states did not restrict Medicaid eligibility based on immigration status.⁶ But in the 1970s, states began to restrict immigrants' access to Medicaid and various economic assistance programs. This policy response was in no small part due to anti-immigrant sentiment that coincided with immigration from Latin America, Asia, and Africa outpacing that from Europe, as well as racist and xenophobic assumptions about who "deserved" this assistance.⁷

These policies and their resulting legal challenges paved the way for the Nixon Administration to bar people without a documented immigration status (also known as people who are undocumented) from cash assistance and Medicaid.⁸ After a federal court invalidated these restrictions in 1986, Congress passed a law⁹ barring federal reimbursement of Medicaid services, except those for life-threatening medical emergencies, provided to people without a documented immigration status. Later, a 1996 law¹⁰ significantly weakened programs that help people meet their basic needs. This included imposing additional immigration-related eligibility restrictions for many people with lawful immigration statuses.¹¹ As a result of these policy decisions, many immigrants today — who are mostly people of color — struggle to meet their basic needs.¹²

⁴ Office of Health Policy, Assistant Secretary for Planning and Evaluation, U.S. Department of Health and Human Services, "Health Coverage Under the Affordable Care Act: Current Enrollment Trends and State Estimates," March 23, 2023, <https://aspe.hhs.gov/sites/default/files/documents/8e81cf90c721dbbf58694c98e85804d3/health-coverage-under-aca.pdf>.

⁵ Thomas C. Buckmueller and Helen G. Levy, "The ACA's Impact On Racial and Ethnic Disparities In Health Insurance Coverage And Access To Care," *Health Affairs*, Vol. 39, No. 3, March 2020, <https://www.healthaffairs.org/doi/10.1377/hlthaff.2019.01394>.

⁶ Medha D. Maklouf, "Laboratories of Exclusion: Medicaid, Federalism, & Immigrants," *New York University Law Review*, 2020, <https://www.nyulawreview.org/wp-content/uploads/2020/12/NYULawReview-Volume-95-Issue-6-Makhlouf.pdf>.

⁷ Cybelle Fox, "Unauthorized Welfare: The Origins of Immigrant Status Restrictions in American Social Policy," *Journal of American History*, Vol. 102, No. 4, March 2016, <https://doi.org/10.1093/jahist/jav758>.

⁸ *Ibid.*

⁹ The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA).

¹⁰ The Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA).

¹¹ Sarah R. Coleman, "Immigration After 1965," Organization of American Historians, <https://www.oah.org/tah/immigration-history/immigration-post-1965/>.

¹² Charles Kamasaki, "U.S. Immigration Policy: A Classic, Unappreciated Example of Structural Racism," Brookings, March 26, 2021, <https://www.brookings.edu/articles/us-immigration-policy-a-classic-unappreciated-example-of-structural-racism/>.

Health Programs Restrict Coverage for People Who Are Immigrants, Worsen Health Outcomes

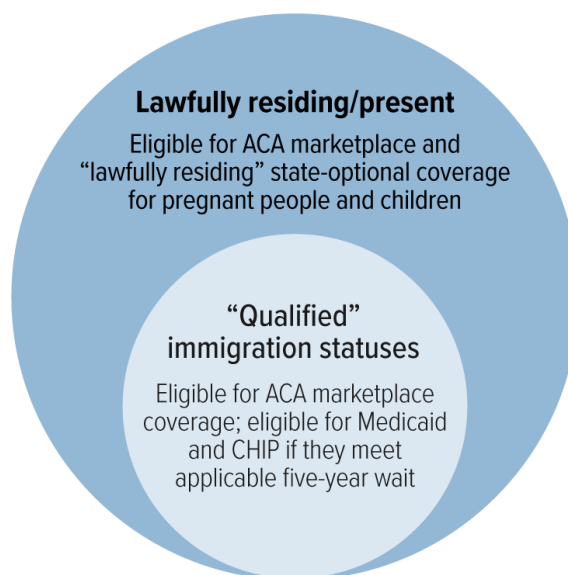
Federal law restricts both people who do not have a documented status and many people who have lawful immigration statuses from enrolling in Medicaid and CHIP, with some exceptions. In general, to enroll in these programs people must have a “qualified” immigration status, but that in itself is not enough. Most people who obtain qualified statuses — including people with lawful permanent resident status, or green cards — must wait five years or longer before they can enroll in Medicaid or CHIP.¹³

Many people who are lawfully residing in the U.S., for example people with temporary protected status, do not have a qualified immigration status. These individuals — as well as people with a qualified status who are subject to the five-year waiting period — are blocked from Medicaid eligibility due to their status but may enroll in ACA marketplace coverage and receive income-based financial help with premiums and out-of-pocket costs, if they meet all other eligibility requirements. People with Deferred Action for Childhood Arrival (DACA)¹⁴ and people without a documented immigration status are barred entirely from full coverage under Medicaid, CHIP, and the ACA marketplaces, and their jobs often do not offer health coverage.¹⁵ (For information on various immigrations statuses and their implications for coverage eligibility, see appendixes I and II.)

People without a documented immigration status may be able to access no- or low-cost health care using a patchwork system of funding sources, but coverage may not be comprehensive or guaranteed. Medicaid can pay health care providers for health services provided to people experiencing medical emergencies who would meet all Medicaid eligibility

FIGURE 2

Many People With Lawful Immigration Statuses Are Barred From Medicaid and CHIP



Note: CHIP = Children's Health Insurance Program. ACA = Affordable Care Act.

Source: HealthCare.gov, “Coverage for Lawfully Present Immigrants”

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¹³ States may elect to provide Medicaid and CHIP coverage to children and pregnant individuals who have lawfully residing immigration statuses in the United States, including those within their first five years of having their lawful status.

¹⁴ DACA recipients are lawfully present immigrants. However, unlike other people with a lawfully present immigration status, DACA recipients are barred from enrolling in marketplace coverage and are ineligible for state-optional Medicaid and CHIP programs for children and pregnant people. See: National Immigration Law Center, “Frequently Asked Questions: Exclusion of Youth Granted ‘Deferred Action for Childhood Arrivals’ from Affordable Health Care,” updated December 2022, <https://www.nilc.org/issues/health-care/acadacafaq/>.

¹⁵ KFF, “Key Facts on Health Coverage of Immigrants,” September 17, 2023, <https://www.kff.org/racial-equity-and-health-policy/fact-sheet/health-coverage-and-care-of-immigrants/>.

requirements if it weren't for their immigration status.¹⁶ Some people who do not have a documented status may receive free or low-cost preventive and primary care from community health centers if such services are available in their areas and they meet the income requirements. Many people, however, are left with few options and as a result go without care, delay care, and are charged exorbitant out-of-pocket costs for care provided without insurance or through plans in the private market.

Even people eligible to enroll in health coverage programs may be deterred from enrolling due to the “chilling effect.” That is, they fear — understandably given confusing immigration policies and the anti-immigrant sentiments that some policymakers stoke — that receiving benefits could jeopardize their or their family members’ ability to gain an immigration status (for example, obtain a green card) or newly immigrate to the U.S., or otherwise result in a negative immigration consequence. This chilling effect worsened after the Trump Administration issued severe changes, since reversed, to the “public charge” policy.

Public charge is part of the immigration application process for many people seeking to come to the U.S. or to change their status within the country. In this assessment, immigration authorities are seeking to ensure immigration applicants do not become “dependent on the government for subsistence.”¹⁷ This assessment includes but is not limited to a lookback on past use of certain public benefits.¹⁸

The Trump Administration’s changes added to the list of benefits that would be counted negatively in public charge assessments, but the chilling effect also dissuaded significant shares of people who were not subject to public charge determinations (such as citizen children of non-citizen parents) from enrolling.¹⁹ Some chilling effect persists even after the Biden Administration’s reversal of these changes to the public charge policy, and has been exacerbated in states that have enacted laws hostile to people who are immigrants.²⁰

All of these factors contribute to disproportionately high rates of uninsurance among people who are immigrants. In 2023, among the non-elderly population, 18 percent of people with lawful immigration status and 50 percent of people with no documented immigration status were

¹⁶ Also referred to as “Emergency Medicaid.”

¹⁷ USCIS, “Public Charge Resources,” updated July 10, 2023, <https://www.uscis.gov/green-card/green-card-processes-and-procedures/public-charge/public-charge-resources>.

¹⁸ In 1999, the federal government issued guidance specifying that participation in certain cash assistance programs, such as Social Security Insurance (SSI) or Temporary Assistance for Needy Families (TANF), would be viewed negatively in public charge determinations but that accessing programs providing non-cash supports such as food assistance or health coverage would not. In 2019, the Trump Administration finalized a rule that negatively factored in the use of additional public benefits, including Medicaid for non-pregnant adults, the Supplemental Nutrition Assistance Program (SNAP), and several housing assistance programs, in public charge determinations. See: KFF, “Changes to ‘Public Charge’ Inadmissibility Rule: Implications for Health and Health Coverage,” August 12, 2019, <https://www.kff.org/racial-equity-and-health-policy/fact-sheet/public-charge-policies-for-immigrants-implications-for-health-coverage/>.

¹⁹ Dulce Gonzalez and Hamutal Bernstein, “One in Four Adults in Mixed-Status Families Did Not Participate in Safety Net Programs in 2022 Because of Green Card Concerns,” Urban Institute, August 17, 2023, <https://www.urban.org/research/publication/one-four-adults-mixed-status-families-did-not-participate-safety-net-programs>.

²⁰ Sylvia E. Twersky, “Do state laws reduce uptake of Medicaid/CHIP by U.S. citizen children in immigrant families: evaluating evidence for a chilling effect,” *International Journal for Equity in Health*, Vol. 21, No. 50, April 12, 2022, <https://equityhealth.biomedcentral.com/articles/10.1186/s12939-022-01651-2>.

uninsured, compared to 8 percent of people who are U.S. citizens.²¹ Research shows that people without health coverage access fewer health care services, including important screenings that can detect disease and conditions that need to be treated.²²

Because the cost of health care without insurance is so high, people who are immigrants feel forced to forgo medical care until their situation becomes too urgent to ignore. In 2023, 22 percent of immigrant adults said they skipped or postponed receiving medical care; 40 percent of those who skipped or postponed care said that their health worsened as a result.²³

The Benefits of Coverage, and How to Ensure People Who Are Immigrants Can Access It

People who have health coverage experience better health outcomes and less risk of premature death.²⁴ Coverage also reduces medical debt, lowers the risk of catastrophic health care costs, and improves financial well-being.²⁵ Children with health insurance experience long-term health improvements and achieve greater academic and career success.²⁶

Despite the known benefits of having health coverage, long-standing federal policies have severely limited the federal resources that can make health coverage programs available to many immigrants. There are at least two parts to a comprehensive solution. One is enacting immigration reform so that people who have an undocumented status have a workable pathway to a documented status and citizenship. Another is to end the immigration-related restrictions on health coverage program eligibility. Both the HEAL for Immigrant Families Act²⁷ and the LIFT the BAR Act²⁸ would make significant progress on the latter by expanding eligibility for government health programs to more people with different immigration statuses and by eliminating the five-year waiting period for Medicaid and CHIP.

Congress has so far failed to act on either immigration reform or on removing health coverage restrictions. In the absence of federal action, states have stepped in to expand health coverage to people who are immigrants. Some of these state strategies leverage allowable federal funding, others rely on state funding, and others combine funding sources.

²¹ KFF, “Key Facts on Health Coverage of Immigrants.”

²² Institute of Medicine (US) Committee on Health Insurance Status and Its Consequences, “America’s Uninsured Crisis: Consequences for Health and Health Care,” Coverage Matters, 3, 2009, <https://www.ncbi.nlm.nih.gov/books/NBK214963/>.

²³ Drishti Pillai *et al*, “Health and Health Care Experiences of Immigrants: The 2023 KFF/LA Times Survey of Immigrants,” KFF, September 17, 2023, <https://www.kff.org/racial-equity-and-health-policy/issue-brief/health-and-health-care-experiences-of-immigrants-the-2023-kff-la-times-survey-of-immigrants>.

²⁴ Institute of Medicine, *op. cit.*

²⁵ Madeline Guth, Rachel Garfield, and Robin Rudowitz, “The Effects of Medicaid Expansion under the ACA: Studies from January 2014 to January 2020,” KFF, March 17, 2020, <https://www.kff.org/report-section/the-effects-of-medicaid-expansion-under-the-aca-updated-findings-from-a-literature-review-report/>.

²⁶ Joan Alker and Katrina Wagnerman, “Medicaid and CHIP are Long-Term Investments in Children’s Health and Future Success,” Georgetown University Center for Children and Families, April 10, 2017, <https://ccf.georgetown.edu/2017/04/10/medicaid-a-smart-investment-in-children/>.

²⁷ Health Equity and Access under the Law for Immigrant Families Act of 2023, H.R.5008, <https://www.congress.gov/bill/118th-congress/house-bill/5008>.

²⁸ LIFT the BAR Act of 2023, S.2038, <https://www.congress.gov/bill/118th-congress/senate-bill/2038>.

States that wish to provide coverage beyond federally funded options will need to make a substantial and sustained financial investment and should expect to use mostly state funding. Providing such coverage gives more people the opportunity to be healthy and thrive. There are also some cost-saving options that utilize contributions from existing federally funded programs and services. These funding opportunities are highlighted in text boxes throughout this paper.

States Have Options to Cover Many Children and People Who Are Pregnant With Federal Matching Funding

Medicaid and CHIP eligibility is typically limited to people with qualified immigration statuses who have completed applicable waiting periods. But under federal law, states also have the option to allow children and people who are pregnant to enroll in Medicaid or CHIP — without a waiting period — if they have immigration statuses considered to be “lawfully residing,” which is defined as a person who is “lawfully present” and meets the state’s residency requirements.²⁹

States can also cover people with low incomes during pregnancy regardless of their immigration status through CHIP, by adopting the “from-conception-to-end-of-pregnancy” (FCEP) option.³⁰ And states can use a CHIP Health Services Initiative (HSI) to provide coverage to people with low incomes during the post-pregnancy period, regardless of their immigration status.³¹ States should maximize

Funding Opportunity: States That Expand Coverage to Children Who Are Immigrants and Pregnant People Through CHIP Can Receive Enhanced Federal Matching Funds

States that implement the lawfully residing standard and the CHIP FCEP option can receive federal matching funds to help pay for this coverage. Federal matching funds for most health services provided by Medicaid and CHIP are determined by the federal medical assistance percentage (FMAP), which is based on a state’s per capita income. States with lower per capita income have a higher FMAP, meaning that a larger percentage of their spending is reimbursed by the federal government. States that adopt the lawfully residing option for pregnant people under Medicaid will receive federal matching funds at the same rate as their FMAP for Medicaid.^a States will receive the enhanced CHIP FMAP^b for coverage of children and pregnant people covered under the CHIP lawfully residing option or for health services provided to people under the CHIP FCEP option.^c

^a In fiscal year 2024, the lowest FMAP rate is 50 percent and the highest is 77.27 percent. See KFF, “Federal Medical Assistance Percentage (FMAP) for Medicaid and Multiplier,” <https://www.kff.org/medicaid/state-indicator/federal-matching-rate-and-multiplier>.

^b In fiscal year 2024, the lowest enhanced CHIP FMAP rate is 65 percent, and the highest is 84.09 percent. See KFF, “Enhanced Federal Medical Assistance Percentage (FMAP) for CHIP,” <https://www.kff.org/medicaid/state-indicator/federal-matching-rate-and-multiplier>.

^c Centers for Medicare & Medicaid Services (CMS), “SHO # 10-006: Re: Medicaid and CHIP Coverage of ‘Lawfully Residing’ Children and Pregnant Women,” July 1, 2010, <https://downloads.cms.gov/cmsgov/archived-downloads/smdl/downloads/sho10006.pdf>.

²⁹ The lawfully residing options were created by Section 214 of the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA), now codified at 42 U.S.C. 1396b(v). These options are therefore also known as the CHIPRA 214 options or the ICHIA options, after the bill that was eventually incorporated into CHIPRA (the Immigrant Children's Health Improvement Act (ICHIA)).

³⁰ FCEP was formerly known as the CHIP unborn child option. States with a CHIP Medicaid expansion program can adopt the FCEP option but must create a separate CHIP program to do so. This is known as a combination program structure. For information on CHIP program types in different states, see: KFF, “CHIP Program Name and Type,” September 1, 2022, <https://www.kff.org/other/state-indicator/chip-program-name-and-type>.

³¹ CMS, “SHO #23-004: RE: Section 5112 Requirement for all States to Provide Continuous Eligibility to Children in Medicaid and CHIP under the Consolidated Appropriations Act, 2023,” September 29, 2023, <https://www.medicare.gov/sites/default/files/2023-09/sho23004.pdf>.

opportunities to provide access to health coverage by adopting these options, which can be partially paid for through federal matching funds.

As of 2023, 35 states, three U.S. Territories, and the District of Columbia have adopted the option to cover children under the lawfully residing immigration standard (which includes eliminating the five-year bar), and 27 states, three territories, and D.C. have adopted the lawfully residing option to cover people who are pregnant. (See Figure 3.) Two states (Michigan and Georgia) have adopted, but not yet implemented, the “lawfully residing” options for pregnant people and children. New Hampshire plans to adopt the lawfully residing options for pregnant people and children no later than January 1, 2024.³²

Since 2022, states have had the option to extend comprehensive Medicaid coverage for up to 12 months post-pregnancy.³³ In states that have adopted the lawfully residing option for pregnant people, Medicaid enrollees eligible under the lawfully residing option also qualify for up to 12 months of coverage post-pregnancy.³⁴

In states that have not adopted these options, children and people who are pregnant and meet the ACA marketplace immigration-related requirement can get coverage through the marketplace, but marketplace coverage doesn’t have the same protections and benefits for them. Most Medicaid and CHIP programs have greater cost-sharing protections than ACA marketplace coverage. People can enroll in Medicaid or CHIP at any time, whereas many people³⁵ can only enroll in marketplace coverage during an annual open enrollment period or if they experience a “qualifying life event” that triggers a special enrollment period.³⁶

Children with ACA marketplace coverage may also miss out on certain services that would be available under Medicaid’s Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit. The EPSDT benefit covers important screenings and treatment for conditions identified by

³² CMS, “Medicaid and CHIP Coverage of Lawfully Residing Children & Pregnant Individuals,” updated May 4, 2023, <https://www.medicaid.gov/medicaid/enrollment-strategies/medicaid-and-chip-coverage-lawfully-residing-children-pregnant-individuals>; National Immigration Law Center, “Medical Assistance Programs for Immigrants in Various States,” July 2023, <https://www.nilc.org/wp-content/uploads/2023/07/med-services-for-imms-in-states-2023-7-10-.pdf>.

³³ 42 U.S.C. 1396a(e)(16).

³⁴ To date, 39 states and D.C. have adopted the 12-month post-pregnancy expansion, including 25 states (Arkansas, California, Colorado, Connecticut, Delaware, Hawai’i, Indiana, Kentucky, Maine, Maryland, Massachusetts, Minnesota, New Jersey, New Mexico, New York, North Carolina, North Dakota, Ohio, Pennsylvania, South Carolina, Vermont, Virginia, Washington, West Virginia, and Wyoming) and D.C. that have adopted the lawfully residing option for pregnant people. Nebraska and Nevada have adopted the lawfully residing option for pregnant people and plan to adopt the 12-month post-pregnancy expansion. Wisconsin has adopted the lawfully residing option for pregnant people and plans to adopt a 90-day post-pregnancy expansion. Georgia, Michigan, and New Hampshire have adopted the 12-month post-pregnancy expansion and plan to adopt the lawfully residing option for pregnant people. See KFF, “Medicaid Postpartum Coverage Extension Tracker,” November 14, 2023, <https://www.kff.org/medicaid/issue-brief/medicaid-postpartum-coverage-extension-tracker/>.

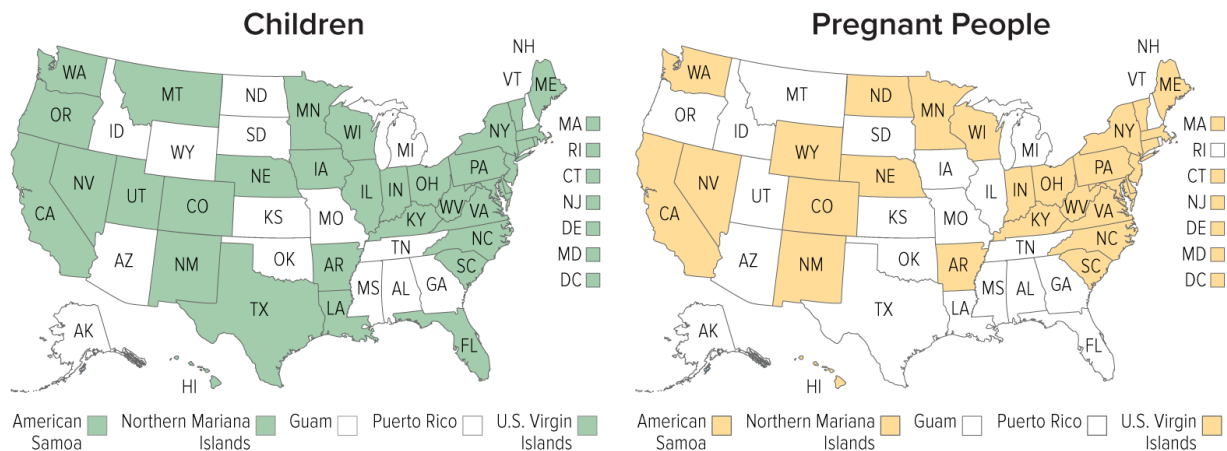
³⁵ In states that use HealthCare.gov, eligible individuals with a household income of up to 150 percent of the federal poverty level (\$21,870 for an individual or \$45,000 for a family of four) can enroll in ACA marketplace coverage at any time. See: CMS, “Marketplace Stakeholder Technical Assistance Tip Sheet on the Monthly Special Enrollment Period for Advance Payments of the Premium Tax Credit – Eligible Consumers with Household Income at or below 150% of the Federal Poverty Level,” updated October 28, 2022, <https://www.cms.gov/ccio/resources/regulations-and-guidance/150fpseptatipsheet>.

³⁶ In all states except Connecticut, Maine, Maryland, New York, New Jersey, and Washington, D.C., becoming pregnant is not considered a qualifying life event for an ACA marketplace special enrollment period. See Louise Norris, “An SEP for your growing family: Does pregnancy cause a special enrollment period?” HealthInsurance.org, <https://www.healthinsurance.org/special-enrollment-guide/an-sep-for-your-growing-family/>.

these screenings, including vision, dental, and hearing services, as well as screening for lead, developmental issues, and behavioral issues.³⁷

FIGURE 3

States Adopting the “Lawfully Residing” Option to Offer Medicaid and/or CHIP to Children and Pregnant People



Note: Medicaid and CHIP eligibility is typically limited to people with qualified immigration statuses and who have gone through applicable waiting periods. But federal law lets states allow children and people who are pregnant to enroll in Medicaid or CHIP — without a waiting period — if their immigration status is “lawfully residing,” that is, they are “lawfully present” and meet the state’s residency requirements. Data are as of November 2023.

Source: KFF, “Medicaid/CHIP Coverage of Lawfully-Residing Immigrant Children and Pregnant Women,” and CBPP analysis

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States can also adopt the CHIP FCEP option, which provides federal matching funds to states that expand access to coverage to people who are pregnant but are ineligible for Medicaid due to their immigration status, including but not limited to people who are undocumented. Most states that have adopted this option provide comprehensive, Medicaid/CHIP like coverage to enrollees, and receive federal matching funds for these services. However, some states have chosen to limit coverage for FCEP enrollees to services that are directly related to pregnancy.³⁸ To date, 20 states have elected the FCEP option, and Colorado plans to join them in 2024. (See Figure 4).³⁹

³⁷ Medicaid.gov, “Early and Periodic Screening, Diagnostic, and Treatment,” <https://www.medicaid.gov/medicaid/benefits/early-and-periodic-screening-diagnostic-and-treatment/index.html>.

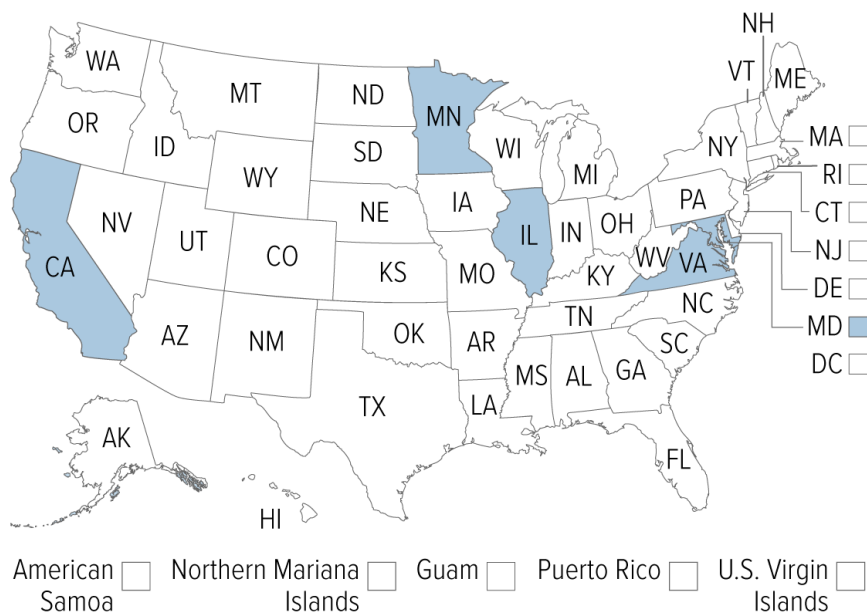
³⁸ Patricia Boozang, Kaylee O’Connor, and Max Blumenthal, “Supporting Health Equity and Affordable Health Coverage for Immigrant Populations: CHIP Coverage Option for Pregnant Immigrants and their Children,” Manatt Health, January 2022, <https://www.shvs.org/wp-content/uploads/2022/01/Supporting-Health-Equity-and-Affordable-Health-Coverage-for-Immigrant-Populations-CHIP-Coverage-Option-for-Pregnant-Immigrants-and-their-Children.pdf>.

³⁹ KFF, “Medicaid and CHIP Income Eligibility Limits for Pregnant Women as a Percent of the Federal Poverty Level,” updated January 1, 2023, <https://www.kff.org/health-reform/state-indicator/medicaid-and-chip-income-eligibility-limits-for-pregnant-women-as-a-percent-of-the-federal-poverty-level/?currentTimeframe=0&selectedDistributions=unborn-child-option-chip-funded&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D>; National Immigration Law Center, *op. cit.*

months) who would otherwise be eligible for Medicaid or CHIP, if not for their immigration status.⁴²

FIGURE 5

States With a CHIP Health Services Initiative (HSI) That Provides Post-Pregnancy Coverage to People Regardless of Immigration Status



Note: Data are as of November 2023. These HSIs are used to provide post-pregnancy coverage to people with low incomes, regardless of their immigration status.

Source: Centers for Medicare & Medicaid Services, “CHIP State Plan Amendments”

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Altogether, 42 states, three territories, and D.C. have used federally funded options to expand Medicaid or CHIP eligibility to some children and/or pregnant people who would otherwise be ineligible because of their immigration status. States can act quickly to take up these options by submitting state plan amendments (SPAs), which are typically approved relatively quickly and can take effect retroactive to the beginning of the quarter in which the SPA was submitted. These options do not require waivers, which typically require public comment and lengthy negotiations with the Centers for Medicare & Medicaid Services (CMS).

⁴² Maggie Clark and Maya Millette, “State Opportunities to Leverage Medicaid and CHIP Coverage to Improve Maternal Health and Eliminate Racial Inequities,” Georgetown CCF, April 25, 2023, <https://ccf.georgetown.edu/2023/04/25/opportunities-to-leverage-medicaid-and-chip-to-improve-maternal-health-and-eliminate-racial-inequities/>; KFF, “Key Facts on Health Coverage of Immigrants.”

States Are Creating Medicaid-Like Coverage Outside of Federally Funded Options

At least 5 states and D.C. have created health coverage programs similar to Medicaid to cover certain groups that do not meet the federal immigration-related eligibility criteria for Medicaid. And other states are following their lead: in 2024, Utah plans to provide CHIP-like coverage to certain uninsured children who do not qualify for federally funded CHIP because of their immigration status.⁴³

To reduce program costs, Medicaid look-alike programs often have narrower eligibility categories or provide fewer health benefits than Medicaid, since states do not receive federal matching funds for participants' care. For example, several states have chosen to restrict eligibility for their Medicaid look-alike programs based on age or pregnancy status. The programs therefore have limitations but are a valuable source of coverage for many.

Eleven states (California, Connecticut, Illinois, Maine, Massachusetts, New Jersey, New York, Oregon, Rhode Island, Vermont, and Washington) and D.C. have created Medicaid look-alike programs for children. Vermont — which has not adopted the FCEP option — has created a Medicaid look-alike program for pregnant people. Five states (Connecticut, Maine, Massachusetts, New York, and Washington) have created look-alike programs for people after pregnancy.⁴⁴ Illinois has created Medicaid look-alike programs for older adults. California, D.C., and Oregon have created Medicaid look-alike programs for children and adults regardless of age or pregnancy status. Finally, three states (Hawai'i, New York, and Pennsylvania) offer look-alike coverage for a limited population, based for example on income or qualifying condition.⁴⁵

While most states' look-alike programs include the same benefits as Medicaid and CHIP, a few states have chosen to limit covered benefits. Connecticut excludes coverage of the EPSDT benefit and non-emergency medical transportation for children of families with incomes at 201-323 percent of the federal poverty level (FPL) (approximately \$29,000-\$47,000 for a household of one or \$60,000-\$97,000 for a family of four, in 2023); Illinois' and Vermont's programs exclude coverage of long-term care.

⁴³ Eligibility for the program is limited to children under 19 who have lived in the state for at least 180 days; have household income between 100-200 percent of the federal poverty level; do not have access to health insurance through a parent, legal guardian, or Medicaid; are not incarcerated or receiving inpatient mental health care; and whose parents have unsubsidized employment. See Utah State Legislature, Senate Bill 0217, 2023 Regular Session. <https://le.utah.gov/~2023/bills/sbillamd/SB0217.htm>.

⁴⁴ Illinois, Maryland, Minnesota, and Virginia provide Medicaid-like coverage to post-pregnancy people through a CHIP HSI, as previously noted. For an interactive map of states adopting Medicaid look-alikes and other approaches, see <https://www.cbpp.org/research/immigration/states-are-providing-affordable-health-coverage-to-people-barred-from-certain#health9-8-23>.

⁴⁵ Hawai'i's program covers people with lawfully residing immigration statuses who are aged, blind, or disabled and do not qualify for Medicaid due to immigration status, as well as people with a "qualified" immigration status who are subject to the five-year bar. New York's program provides Medicaid look-alike coverage for people aged 19 or older who have DACA status. Pennsylvania's program covers people with lawfully residing immigration statuses who have income below approximately 40 percent FPL and are 1) a parent of a child under 21; 2) an adult age 59 or older; 3) a person with a disability; or a person who 4) is a victim of domestic violence, 5) in treatment for drug or alcohol addiction, or 6) caring for an unrelated child or disabled household member.

Funding Opportunity: Leveraging Funding Available Under Medicaid Payment of Emergency Services

Medicaid reimburses health care providers for the treatment of emergency medical conditions experienced by people who meet all requirements for their state's Medicaid program except for the immigration-related eligibility standard. Like other Medicaid expenditures, Medicaid payment for emergency services costs are split between the federal government and the state.

The term “emergency medical condition” is defined by federal law as a condition, including labor and delivery, that places an individual's life or health in immediate danger. But states have significant discretion in defining qualifying medical conditions covered under Medicaid payment for emergencies.

As of 2023, 17 states define kidney failure as an emergency medical condition and thus reimburse providers using Medicaid payment for emergencies for dialysis. One of these states also requires Medicaid payment for emergencies for kidney transplants.^a A handful of states — including Oregon and Washington — have clarified that cancer treatment, behavioral health crisis services, and anti-rejection medications after an organ transplant are medical conditions that can be reimbursed under Medicaid payment for emergency services.^b

Several states allow people to be pre-qualified for Medicaid payment for emergency services, so that if they need treatment for an emergency, they can obtain them without fear that the costs will not be covered. This is particularly helpful in cases when states cover outpatient services such as cancer treatment or dialysis.^c

States can also coordinate Medicaid payment for emergency services with Medicaid look-alike programs in ways that lower state program costs. For example, Vermont's Medicaid look-alike program for pregnant people who are immigrants does not include coverage of labor and delivery, as these services are covered by Medicaid payment for emergency services.^d

Massachusetts' state-funded program, the Children's Medical Security Plan (CMSP), provides health coverage for children under 19 who are ineligible for Medicaid, regardless of their income or immigration status. CMSP covers a range of health services, including primary care, preventive care, urgent care, dental care, mental health outpatient services, and durable medical equipment. However, the program does not cover emergency room services, ambulance services, or inpatient hospital care.^e Because many children enrolled in CMSP are also eligible for Medicaid payment for emergency services or other payment sources, they are shielded from incurring high medical bills due to treatment related to emergencies.

As an alternative to carving out emergency services from Medicaid look-alike coverage, a state could instead factor out the cost of emergency services when determining state-funded program costs. The state could then work with CMS to utilize Medicaid payment for emergency services to reimburse the state for such spending.

^a Katherine Rizzolo *et al.*, “Access to Kidney Care for Undocumented Immigrants Across the United States,” *Annals of Internal Medicine*, June 2023, <https://www.acpjournals.org/doi/10.7326/M23-0202>.

^b Office of Health Policy, Health Policy and Analytics Division, Oregon Health Authority, “HB3352 Healthier Oregon Implementation Report,” January 2023, <https://connectforhealthco.com/get-started/silverenhanced-savings/>; Washington State Health Care Authority, “WAC 182-507-0120 Alien medical for dialysis and cancer treatment, and treatment of life-threatening benign tumors,” revised June 8, 2022, <https://www.hca.wa.gov/free-or-low-cost-health-care/i-help-others-apply-and-access-apple-health/apple-health-alien-emergency-medical>.

^c Jin K. Park, Clarisa Reyes-Becerra, and Medha D. Makhlof, “State Flexibility in Emergency Medicaid to Care for Uninsured Noncitizens,” *JAMA Health Forum*, Vol. 4. No. 7, July 14, 2023, <https://jamanetwork.com/journals/jama-health-forum/fullarticle/2807182>.

^d Department of Vermont Health Access, “Immigrant Health Insurance Plan (IHIP),” <https://dvha.vermont.gov/information-for-non-citizens/immigrant-health-insurance-plan-ihip>.

^e MassHealth, “Services covered under the Children's Medical Security Plan,” <https://www.mass.gov/service-details/services-covered-under-the-childrens-medical-security-plan>.

Unlike Medicaid and CHIP, Medicaid look-alike programs can impose caps on enrollment or close enrollment entirely. Unfortunately, Illinois recently chose to pursue both of these strategies.⁴⁶ The state operates four Medicaid look-alike programs: AllKids serves children younger than 19 with incomes at or below 318 percent FPL; Health Benefits for Immigrant Seniors serves adults 65 and older with income at or below 100 percent FPL and who meet an asset test; Health Benefits for Immigrant Adults serves adults aged 42-64 with incomes at or below 138 percent FPL; and Moms & Babies serves post-pregnancy people who received coverage through the FCEP option, and their children, for up to 12 months.

As of July 1, 2023, due to budget constraints, the Health Benefit for Immigrant Seniors program began operating under a cap of 16,500 enrollees, and the Health Benefits for Immigrant Adults program stopped accepting new enrollees. The Health Benefit for Immigrant Seniors program reached its cap and stopped accepting new enrollees as of November 6, 2023.⁴⁷ Both programs will require enrollees to pay co-payments or co-insurance for some services.⁴⁸

Meanwhile, several other states are expanding their Medicaid look-alike programs. In 2024, California plans to offer Medicaid-like coverage to adults aged 26-49 who would be eligible for Medicaid except for their immigration status,⁴⁹ and New York plans to provide Medicaid-like coverage to people aged 65 and older who would be eligible for Medicaid except for their immigration status.⁵⁰ In 2025, Colorado plans to provide Medicaid-like coverage to children under age 19.⁵¹

States Can Make Comprehensive Individual Health Plans Accessible and Affordable

Two states — Colorado and Washington — make individual health plans accessible and affordable to people with low incomes who are ineligible for ACA marketplace plans due to their immigration status. Both states used a Section 1332 waiver to help support at least parts of their programs. Section 1332 waivers allow states to waive certain provisions of the ACA as long as those changes are at least as successful at providing access to affordable, good-quality health insurance coverage, and do so at the same or lower cost to the federal government.⁵²

⁴⁶ Boram Kim, “Illinois health advocates say changes to state’s program for immigrant adults and seniors will impact access to care,” State of Reform, August 3, 2023, <https://stateofreform.com/featured/2023/08/illinois-health-advocates-say-changes-to-states-program-for-immigrant-adults-and-seniors-will-impact-access-to-care>.

⁴⁷ Lt. Gov. Juliana Stratton, “HFS announces next steps for Health Benefits for Immigrant Seniors program,” October 19, 2023, <https://ltgov.illinois.gov/news/press-release.27160.html>.

⁴⁸ Illinois.gov, “HFS Announces Next Steps for Health Benefits for Immigrant Adults and Seniors Programs,” June 20, 2023, <https://www.illinois.gov/news/press-release.26601.html>.

⁴⁹ California Department of Finance, “California State Budget — 2022-2023, Health and Human Services,” June 27, 2022, <https://ebudget.ca.gov/2022-23/pdf/Enacted/BudgetSummary/HealthandHumanServices.pdf>.

⁵⁰ NY Health Access, “Emergency Medicaid in New York State - Limited Medicaid Coverage for Undocumented Immigrants,” updated October 18, 2023, <http://health.wnyc.com/health/entry/70>.

⁵¹ Colorado General Assembly, House Bill, 22-1289, 2022 Regular Session, <https://leg.colorado.gov/bills/hb22-1289>.

⁵² Sarah Lueck and Jessica Schubel, “Understanding the Affordable Care Act’s State Innovation (‘1332’) Waivers,” CBPP, September 5, 2017, <https://www.cbpp.org/research/health/understanding-the-affordable-care-acts-state-innovation-1332-waivers>.

In 2022, Colorado launched OmniSalud, providing people who do not meet the immigration-related requirements for Medicaid, CHIP, or the ACA marketplace the opportunity to buy one of the state's public option plans.⁵³ Health insurers must offer these plans on the state's ACA marketplace and separately through Colorado Connect, where OmniSalud plans are available for enrollment. All public option plans are required to have a standardized set of benefits, have reduced premiums, and maintain culturally responsive provider networks, as defined by the state.⁵⁴

Within OmniSalud, the SilverEnhanced Savings program is available to those who qualify for OmniSalud while also having incomes at or below 150 percent FPL (approximately \$22,000 for an individual, or \$45,000 for a family of four, in 2023). People enrolled in the SilverEnhanced Savings program do not have premium costs and have very low cost sharing when they access services. But the state also established a cap of 10,000 enrollees on the SilverEnhanced Savings program due to budget limitations. In 2023, enrollment surpassed the state's projections and reached the cap within six weeks of the start of the program. The state increased this cap to 11,000 enrollees in 2024, and the cap was reached within two days of open enrollment.⁵⁵ In contrast, enrollment in unsubsidized OmniSalud coverage has remained minimal, highlighting the importance of affordable premiums and other costs.

Funding Opportunity: Reinvesting Savings From Other Health Care Initiatives

Colorado's Section 1332 waiver, which continues the state's reinsurance program and requires insurers to offer lower premiums for public option plans, is expected to generate federal savings of \$13 million in 2023 and \$515 million over the five-year period of the waiver. Savings from these programs, along with revenue from state hospital and premium assessments, contribute to the state's Health Insurance Affordability Enterprise, which is used to finance health insurance affordability initiatives. These initiatives include the reinsurance program, additional premium assistance for ACA marketplace enrollees, and the SilverEnhanced Savings program.^a Policymakers and advocates who are interested in following Colorado's example should consider opportunities to invest savings from other state health initiatives to fund coverage expansions for people who are immigrants.

^a Colorado Department of Regulatory Agencies, Department of Insurance, "Colorado Section 1332 Innovation Waiver Amendment Request - Colorado Option," November 30, 2021, <https://drive.google.com/file/d/1SUy-iNz3i7IIRTPTqy2OJgNYH1oyN5mX/view>.

Washington State's approved Section 1332 waiver will allow people to enroll in the state's ACA marketplace regardless of their immigration status beginning in 2024. The state is planning to provide premium subsidies for any marketplace enrollee with income at or below 250 percent of the federal poverty level (approximately \$36,000 for a household of one, or \$75,000 for a family of four, in 2023). Washington has appropriated \$110 million over two years to fund these additional

⁵³ Connect for Health Colorado, "OmniSalud," <https://connectforhealthco.com/get-started/omnisalud/>.

⁵⁴ Colorado Department of Regulatory Agencies, Division of Insurance, "Colorado Option," <https://doi.colorado.gov/insurance-products/health-insurance/health-insurance-initiatives/colorado-option>.

⁵⁵ Angeline McCall, "Health insurance for undocumented Coloradans reaches enrollment cap in two days," 9News, November 26, 2023, <https://www.9news.com/article/news/health/health-insurance-undocumented-coloradans-reaches-enrollment-cap/73-fc14a01a-9e2b-4c2b-90c4-4d6fa16aa41b>.

premium subsidies for all marketplace enrollees, \$10 million of which is earmarked for people who are ineligible for federally funded premium assistance because of their immigration status.⁵⁶

While both Colorado and Washington used a Section 1332 waiver to implement aspects of their programs, states do not need waiver approval to implement similar programs. For example, a state could combine Colorado's and Washington's approaches by requiring insurers to offer marketplace-like coverage outside of the ACA marketplace for people who are barred from ACA marketplace coverage because of their immigration status. The state can then use state funds to lower premiums and cost sharing for enrollees. This type of initiative could be an attractive option for states that do not expect a Section 1332 waiver to generate significant cost savings.

Expanding Coverage Through the Basic Health Program or Other State-Specific Health Programs

To date, most states that have used their own funds to expand health coverage to immigrants have based their programs on Medicaid or ACA marketplace coverage. However, one state — Minnesota — has used state funds to enable people with DACA status to enroll in its Basic Health Program (BHP). States have the option to create a BHP to provide comprehensive health coverage — and receive a 95 percent federal match for doing so — for U.S. citizens and lawfully present individuals (including those subject to the five-year bar) who have incomes at 133-200 percent FPL. This a group that would otherwise be eligible for ACA marketplace coverage with federal financial assistance.

Just two states — Minnesota and New York — have implemented BHPs. Both states have designed their BHPs to offer lower premiums and cost sharing than enrollees would otherwise have in an ACA marketplace plan. Beginning in 2025, Minnesota intends to allow all people with incomes between 133 and 200 percent FPL, regardless of immigration status, to enroll in its BHP, using state funds for the cost of coverage for those ineligible for federal funds.⁵⁷

Other states can learn from Minnesota by considering how best to use any existing state health coverage programs, such as high-risk pools or State Employee Health Plans, to reach those most in need of health coverage.

Operational Considerations to Improve Access

Once a program to expand health coverage for people who would otherwise be ineligible due to immigration status has been approved and funded, states must make several logistical and operational decisions.

- **Phasing in implementation.** For both financial and operational reasons, some states have launched coverage expansions for immigrants within a limited population and subsequently expanded eligibility. For example, in 2016, California launched a Medicaid look-alike program

⁵⁶ Washington Legislature, Engrossed Substitute Senate Bill 5187 § 214, 2023 Regular Session, <https://lawfilesexternal.wa.gov/biennium/2023-24/Pdf/Bills/Senate%20Passed%20Legislature/5187-S.PL.pdf?q=20230516172937>.

⁵⁷ Minnesota Statutes 2023, Section 256L.04 Subdivision 10, 2023, <https://www.revisor.mn.gov/statutes/cite/256L.04>.

for children under age 19 with low incomes, regardless of immigration status.⁵⁸ In 2020, the state expanded eligibility to young adults aged 19-25 and expanded eligibility to adults 50 years and older in 2022.⁵⁹ California is planning to expand eligibility to all low-income residents, regardless of age or immigration status, in 2024.⁶⁰

- **Pre-registering people for Medicaid payment of emergency services.** Medicaid reimburses health care providers for the treatment of emergency medical conditions experienced by people who meet all of the Medicaid eligibility requirements, except for the immigration-related requirements. However, sometimes people do not know about this or have trouble navigating the application process.

All states should pre-register people for Medicaid payment of emergency services so that if someone encounters a life-threatening medical condition, Medicaid seamlessly covers those costs. Otherwise, people may not know that their care will be reimbursed if they need emergency services and this may prevent them from getting care if they experience a serious health concern.

Pre-registration should also be part of implementing Medicaid look-alike programs. Pre-registration can reduce the costs of funding these expansion programs because states would not have to cover the full cost of providing emergency services for people enrolled in their Medicaid look-alike programs. Look-alike programs could pre-register people at the same time they enroll them in the program.

Eligible people who do not pre-register can still have their medical emergencies paid for by Medicaid by applying after the emergency; pre-registration just helps people have peace of mind and makes things smoother for hospitals as well.

- **Improving the application and enrollment experience.** As part of any state-funded expansion, states should consider households composed of people with different citizenship or immigration statuses and how to make accessing care and coverage as uniform as possible across family members. For example, Washington’s 1332 waiver program will allow people who are eligible for expanded coverage for immigrants to enroll in the same health plan as household members who have regular marketplace coverage.⁶¹ Similarly, Oregon’s Medicaid look-alike program, known as Healthier Oregon, provides all enrollees with the same choice of managed care plans (known as coordinated care organizations, or CCOs), regardless of immigration status.⁶² To make enrollment even easier, the state automatically transfers people receiving CHIP FCEP coverage and people pre-registered for Medicaid payment for emergencies into Healthier Oregon.

⁵⁸ The Children’s Partnership, “Health 4 All Kids FAQs,” <https://health4allkids.org/faq/>.

⁵⁹ California Department of Health Care Services, “Young Adult Expansion,” <https://www.dhcs.ca.gov/services/medicaid/eligibility/Pages/youngadultexp.aspx>; and “Older Adult Expansion,” <https://www.dhcs.ca.gov/services/medicaid/eligibility/Pages/OlderAdultExpansion.aspx>.

⁶⁰ Adam Beam and Don Thompson, “California first to cover health care for all immigrants,” AP News, June 30, 2022, <https://apnews.com/article/health-california-immigration-gavin-newsom-medicare-b09edcb2b89ab041b520f431f8aab4b6>.

⁶¹ Washington Health Benefits Exchange, “Washington Section 1332 Waiver Application,” updated August 3, 2022, <https://www.wahbexchange.org/content/dam/federal-guidance/WA%20Section%201332%20Waiver%20Application-updated%208-3.pdf>.

⁶² Office of Health Policy, Health Policy and Analytics Division, Oregon Health Authority, “Healthier Oregon: Better Care for More People,” January 2023, <https://sharedsystems.dhsoha.state.or.us/DHSForms/Served/le-110196.pdf>.

- **Combatting the chilling effect.** People who are immigrants — especially people who are undocumented and their households — may understandably fear that providing information to government programs would lead to immigration consequences, even when that is not the case. It is therefore essential that state programs that serve these populations implement and communicate robust data privacy protections. For example, the website for Colorado’s OmniSalud program clearly states that the program will not ask applicants to disclose their immigration status, that personally identifiable information will not be shared with federal partners for any reason, and that applicants’ and enrollees’ information cannot be used for immigration enforcement. The website also states that enrolling in health insurance through OmniSalud will not jeopardize a person’s ability to update their immigration status or enter the U.S.⁶³

⁶³ Connect for Health Colorado, *op. cit.*

Appendix I: Federal Immigration-Related Eligibility Standards for Medicaid and CHIP

People must have one of these immigration statuses, as set out in federal law, to qualify for Medicaid or CHIP

People with “qualified” immigration statuses:

- Lawful permanent resident (LPR/green card holder)
- Refugee
- Asylee
- Cuban/Haitian entrant
- Someone paroled into the U.S. for at least one year
- Conditional entrant
- Someone granted withholding of deportation or withholding of removal
- Battered spouse, child, and parent
- Trafficking survivor and his/her spouse, child, sibling, or parent
- Compact of Free Association (COFA) (for Medicaid only)

People who don’t have “qualified” immigration statuses, but meet the eligibility standard:

- Member of a federally recognized Indian tribe or American Indian born in Canada
- Someone with an Iraq/Afghan special immigrant visa

People with the “qualified” and not “qualified” statuses listed above are also subject to a five-year waiting period for Medicaid and CHIP; the five years begin when a person obtains the immigration status. People who are not subject to the five-year bar:⁶⁴

- People who have refugee or asylee statuses and people granted withholding of deportation/removal
- People with one of the “Cuban/Haitian entrant” statuses listed in 45 C.F.R 401.2
- People with LPR status with ten years’ credit for working in the U.S.
- People arriving from Iraq or Afghanistan who have or are in the process of applying for special immigrant visa status

⁶⁴ People who adjust to LPR status after having a status not subject to the five-year-bar continue to be exempt from the bar.

- Some people from Afghanistan or Ukraine who were granted parole into the U.S.⁶⁵
- Survivors of trafficking
- Citizens from nations under the Compacts of Free Association (COFA) (for Medicaid only)
- Qualified immigrants who are U.S. veterans or on active military duty and their spouses or children
- People who physically entered the U.S. before August 22, 1996 and remained in the U.S. continuously until obtaining a qualified status
- Children and pregnant people who are lawfully residing in the U.S. (at state option)

⁶⁵ People arriving from Afghanistan with a special immigrant visa or through a grant of parole are not subject to the five-year bar until March 21, 2023, or for the term of parole granted, whichever is later. People arriving from Ukraine are not subject to the five-year bar for the term of parole granted.

Appendix II: Federal Immigration-Related Eligibility Standards for the ACA Marketplace and State-Optional Medicaid/CHIP Coverage for Children and People Who Are Pregnant

People must have one of these immigration statuses to qualify for the ACA marketplace and state-optional Medicaid/CHIP coverage for children and people who are pregnant:

People with “lawfully present/residing” immigration statuses:

- Lawful permanent resident (LPR/green card holder)
- Refugee
- Asylee
- Cuban/Haitian entrant
- Someone paroled into the U.S. for at least one year
- Conditional entrant
- Someone granted withholding of deportation or withholding of removal
- Battered spouse, child, and parent
- Trafficking survivor and his/her spouse, child, sibling, or parent
- Citizens from nations under the Compacts of Free Association (COFA)
- Member of a federally recognized Indian tribe or American Indian born in Canada
- Someone with an Iraq/Afghan special immigrant visa
- Someone granted relief under the Convention Against Torture (CAT)
- Someone with temporary protected status (TPS)
- Someone with deferred enforced departure (DED)
- Someone with deferred action (except people with DACA)⁶⁶
- Someone paroled into the U.S. for less than one year
- Individual with non-immigrant status — includes worker visas; student visas; U visas (for victims of certain crimes who have suffered mental or physical abuse and are willing to assist law enforcement or government officials in the investigation or prosecution of the criminal activity); and many others
- Someone with an administrative order staying removal issued by the Department of Homeland Security
- Lawful temporary resident
- Someone in the Family Unity Program

⁶⁶ Exception: Individuals granted deferred action under the 2012 DACA program are not eligible to enroll in coverage in the ACA marketplace.

Applicants for any of these statuses:

- LPR with an approved visa petition
- Special Immigrant Juvenile Status
- Victim of Trafficking Visa (T visa)

Applicants for these statuses and must also have employment authorization:⁶⁷

- Withholding of deportation or withholding of removal, under the immigration laws or under the Convention Against Torture (CAT)
- Applicant for Temporary Protected Status
- Registry Applicants
- Order of Supervision
- Applicant for Cancellation of Removal or Suspension of Deportation
- Applicant for Legalization under IRCA
- Applicant for LPR under the LIFE Act
- Applicants for asylum

⁶⁷ Applicants for asylum and applicants for withholding of deportation or withholding of removal, under immigration laws or under the Convention Against Torture (CAT), must have been granted employment authorization or be under the age of 14 and have had an application pending for at least 180 days to be eligible.