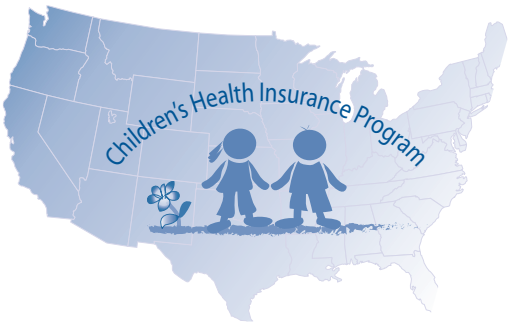

Expanding Coverage for Recent Immigrants:
CHIPRA Gives States New Options

The Children's Health Insurance Program (CHIP) was created in 1997 to provide affordable health coverage to low-income children in working families who make too much money to be eligible for Medicaid but not enough to afford private coverage. The program currently covers more than 7 million children. In February 2009, after a protracted political fight, Congress enacted, and President Obama signed, legislation that renewed CHIP through the end of 2013 and expanded its scope. This series of issue briefs examines the new provisions that were included in the reauthorization and how they will affect implementation in the coming months.

Up until the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA) was passed, there was a so-called "five year bar" in place for legal immigrant children and pregnant women. The bar, which was imposed as part of welfare reform legislation in 1996, prohibited most legal immigrants from enrolling in Medicaid or CHIP during the first five years they lived in the United States.[1] States still had the option to use their own funds to cover legally residing immigrants, but no federals funds have been available for health coverage for these individuals since 1996.

Section 214 of CHIPRA officially lifts this bar for children and pregnant women, although all other legal immigrants are still ineligible for Medicaid and CHIP during their first five years in the country. *This new option does not change existing laws that ban undocumented immigrants from enrolling in Medicaid or CHIP.*

Who is eligible for coverage?

Any state can choose to take advantage of the new option to provide coverage to legally residing immigrant children and pregnant women. In choosing to adopt the new option, states have some flexibility to decide which recently arrived legal immigrants to cover:

- children and pregnant women,
- just children, or
- just pregnant women.

States may also choose whether to take up the option in Medicaid, or in both Medicaid and CHIP. (In order to take up the option in CHIP, a state must also take it up in Medicaid.[2]) Essentially, the provision allows states to disregard how long a legal immigrant child or pregnant woman who applies for Medicaid or CHIP has been in the country. All other eligibility criteria remain the same.

What does "lawfully residing" mean?

Although this provision of CHIPRA may seem fairly straightforward, a complication arose because of the way that the legislation was drafted. CHIPRA specifically allows states to cover immigrant children and pregnant women who are "lawfully residing in the United States."[3] This description is slightly different from the language that is used to describe legal immigrants in other parts of federal law. Thus, it will be up to the Department of Health and Human Services (HHS) to define what this new phrasing means. Forthcoming guidance will likely embrace a very broad definition that includes children and pregnant women who are considered "qualified immigrants" (the term that describes the group of legal immigrants that was originally subject to the five year bar[4]), as well as other groups of recent immigrants who are in the country legally.[5]

It is not yet clear whether states with laws that allow them to cover legal immigrants under this option will need to change their laws to include the words "lawfully residing" to describe the immigrants they cover under this option, or if the more common "qualified immigrants" terminology will be acceptable. It is also unclear whether a state must cover *all* legal immigrants that CMS considers "lawfully residing," or if a state can choose to cover only certain subsets of this group.

How does CHIPRA change income calculations?

The new provision also makes an important improvement to how income is calculated for legal immigrants. For certain legal immigrants who have sponsors during their transition to permanent residency in the United States, federal law has required that when determining eligibility for federal programs like Medicaid, a portion of the sponsor's income must be counted as if it were part of the immigrant's income—even after the individual had been in the country for five years. This was the case even though this income did not belong to the individual who was applying for coverage and was rarely available to help the individual pay for coverage. This requirement resulted in individuals who would otherwise be income-eligible for coverage being determined to be ineligible.

CHIPRA lifts this "sponsor deeming" requirement for immigrant children and pregnant women in states that take up this new option. These individuals' income will be calculated in the same way that their state calculates income for all other children and pregnant women who apply for Medicaid or CHIP.

How many people could be covered?

It is difficult to quantify exactly how many people could potentially gain coverage in any given state if the state were to take up this new option. The immigrant population is more transient, both in terms of employment and in place of residence, which can make it difficult to estimate

how many people are eligible in any one state.[6] However, the bottom line is that the portion of the population that is foreign-born, has been in the country for fewer than five years, and is otherwise eligible for Medicaid or CHIP is quite small. *Lifting the five year bar will not add a large number of children or pregnant women to the Medicaid and CHIP rolls, nor will it be very costly to states or to the federal government*.[7] However, it will provide access to critical health care services for people who otherwise would have no other way to get that care at a time of life that is particularly important for future health, growth, and development.

How is the new option financed?

Children

States that take up the option to cover legal immigrant children in Medicaid and/or CHIP can receive the (higher) federal CHIP matching rate for that coverage, even for those children who qualify for Medicaid rather than CHIP. This is because federal CHIP law defines children who are eligible for the CHIP matching rate—so-called "targeted low-income children"—as any child who would not have been eligible for Medicaid in his or her state when CHIP was enacted in 1997. Since legally residing immigrant children who had been in the country for fewer than five years were ineligible for Medicaid at that time due to the five year bar, they are considered to be targeted low-income children.

This means that if a state chooses to provide Medicaid and CHIP coverage to legal immigrant children, although the family's income will determine whether the child will enroll in Medicaid or CHIP, the state will automatically receive the higher CHIP federal matching rate for the child's coverage regardless of which program he or she enrolls in (and the federal payments will be deducted from the state's CHIP allotment).

Also of note, states whose current Medicaid matching rate is higher than their CHIP matching rate due to the economic stimulus package will receive the higher of the two rates for Medicaid-eligible children.[8]

States can receive the higher CHIP matching rate only for coverage of legal immigrant children in Medicaid who have been in the United States for fewer than five years. Once a child has been in the country for five years, the federal matching rate reverts to the Medicaid matching rate. This is because the child is then considered part of the category of children who would have been eligible for Medicaid when CHIP was enacted in 1997, and thus, is no longer considered a targeted low-income child as described in the CHIP statute.

Alternatively, states have the option to receive the matching rate that corresponds to the program the child enrolls in from day one, although there is little reason for most states to choose this option. If a state were close to spending its entire federal CHIP allotment, it might consider taking the Medicaid matching rate for legal immigrant children and pregnant women who are Medicaid enrollees, but most states are nowhere near spending their entire federal allotment at this time.

Pregnant Women

States will receive their Medicaid matching rate for covering legal immigrant pregnant women in Medicaid and their CHIP matching rate for pregnant women who are covered in CHIP. Note that while states are required to cover certain pregnant women in Medicaid, until CHIPRA was enacted in 2009, states could provide comprehensive CHIP benefits to pregnant women only if they received special permission from the federal government via a Section 1115 waiver. Thus, only a few states currently provide coverage to pregnant women in CHIP (other than through the CHIP "unborn child option," which covers only pregnant related services).

Are states taking advantage of the new option?

States that Already Cover Legal Immigrants

More than half of all states already offer state-funded health coverage to legal immigrant children and/or pregnant women (see the table on pages 6 and 7). These states have every reason to take advantage of this option, since they can receive federal matching funds for services that they are already providing.[9]

Once a state has opted to receive federal funds for Medicaid and CHIP coverage of legal immigrant children and/or pregnant women (which is accomplished through obtaining state plan amendments to the state's Medicaid and CHIP plans), it will receive federal matching dollars for its expenditures, thereby reducing the cost to states by between 56.2 percent and 79.6 percent, depending on the state and which matching rate is used.[10]

Most of the states with state-funded coverage for legal immigrants are already pursuing the new option to cover legal immigrant children, and, in some cases, pregnant women as well.

States that Do Not Currently Offer Coverage to Legal Immigrants

States that do not currently offer any coverage for legal immigrant children and pregnant women now have the *option* to cover these groups in Medicaid and CHIP. Although state budget crises have largely put a damper on state coverage expansion efforts, support remains strong for expanding children's coverage, and some states have already proposed or passed legislation to take up the new immigrant coverage option.

- **Colorado** passed legislation in May 2009 that will allow the state to cover legal immigrant children in Medicaid and CHIP beginning in July 2010 if the funding is available to expand coverage at that time. The state has also submitted a state plan amendment to provide Medicaid to legal immigrant pregnant women with incomes up to 133 percent of the federal poverty level.

- **Iowa** also passed health coverage legislation in 2009 that included coverage for legal immigrant children and pregnant women in Medicaid and legal immigrant children in CHIP.

Given the uncertainty surrounding state budgets, as well the outcome of the current health reform debate in Congress, states may be somewhat reluctant to expand coverage. However, the magnitude of an expansion to legal immigrant children and pregnant women is likely to be quite small; states need not fear huge increases in Medicaid and CHIP enrollment or expenditures if they begin to cover these individuals. At the same time, *for the newly covered children and pregnant women, the chance to get the health care they need when they need it—without having to wait an arbitrary five years—is priceless*.

State advocates should consider encouraging their legislatures to pass whatever legislation is necessary to allow coverage for legal immigrant children and pregnant women in Medicaid and CHIP, and, if necessary, can make this coverage contingent on the availability of state funds (as Colorado and Iowa have done). Such a change may not result in immediate coverage for children and pregnant women, but it would at least establish the framework and allow for coverage in the future.

Why should states expand coverage?

Clearly, the current budget climate presents a barrier to new coverage for legal immigrants in most states, even where the political climate is otherwise favorable to expanding coverage for immigrant children and pregnant women. Still, in addition to improving their residents' health, states that cover these children and pregnant women will also reap other benefits, as follows:

- Women without access to prenatal care are four times more likely to deliver low birth weight infants and seven times more likely to deliver prematurely than women who receive prenatal care. Covering uninsured children and pregnant women through Medicaid can cut unnecessary hospitalizations, producing substantial savings by reducing expensive hospital care costs.[11]
- Covering these children and pregnant women will help guarantee that states do not see a drop in their annual CHIP allotment, since this coverage will "count" toward CHIP expenditures that will be taken into account during the re-basing process in 2011 (see Families USA's brief on CHIP financing, *More Funding for CHIP, Different Rules: How Does CHIPRA Change CHIP Funding?*).
- Although health reform may provide subsidies to low- and middle-income legally residing immigrants if it is enacted, these subsidies will likely be unavailable for several years. Years can be a lifetime for a child to wait! Covering these children and pregnant women now means reduced uncompensated care costs for the state to pay and a healthier start for the families involved.

State Coverage of Legally Residing Immigrant Children and Pregnant Women*

State	Did the state cover some categories of legally residing individuals with state-only funds before CHIPRA was enacted?[1]		Is the state covering legally residing immigrants under the new option?		Effective Date of Coverage under The New Option
	Children	Pregnant Women	Children	Pregnant Women	
Alaska	Yes	Yes	No	No	
Arkansas	No	Yes (CHIP unborn child option)	No	No	
California	Yes	Yes (CHIP unborn child option)	Yes (Medicaid and CHIP); approved	Yes (Medicaid and CHIP); approved	April 1, 2009
Colorado	No	Yes	Yes[2]	Yes[2]	
Connecticut	Yes	Yes	Yes (Medicaid and CHIP); approved	Yes (Medicaid); approved	April 1, 2009
Delaware	Yes	Yes	No	No	
District of Columbia	Yes	Yes	Yes (Medicaid); awaiting approval	Yes (Medicaid); awaiting approval	July 1, 2009
Florida	No[3]	No	No[4]	No	
Hawaii	Yes	Yes	Yes (Medicaid); approved	Yes (Medicaid); approved	April 1, 2009
Illinois	Yes	Yes (CHIP unborn child option)	Yes (Medicaid and CHIP); awaiting approval	Yes (Medicaid); awaiting approval	April 1, 2009
Iowa	No	No	Yes (Medicaid and CHIP); approved	Yes (Medicaid); approved	July 1, 2009
Louisiana	No	Yes (CHIP unborn child option)	No	No	
Maine	Yes	Yes	Yes[5] (Medicaid); awaiting approval	Yes (Medicaid); awaiting approval	July 1, 2009
Maryland	Yes	Yes	Yes (Medicaid); awaiting approval	Yes (Medicaid); awaiting approval	December 1, 2009
Massachusetts	Yes	Yes (Medicaid and CHIP unborn child option)	Yes (Medicaid up to 150% of poverty[6]); approved	Yes (Medicaid up to 150% of poverty); approved	August 29, 2009
Michigan	No	Yes (CHIP unborn child option)	No	No	
Minnesota	Yes	Yes (CHIP unborn child option)	Yes[7]	Yes[7]	
Nebraska	Yes	Yes (CHIP unborn child option)	No	No	

State	Did the state cover some categories of legally residing individuals with state-only funds before CHIPRA was enacted?[1]		Is the state covering legally residing immigrants under the new option?		Effective Date of Coverage under The New Option
	Children	Pregnant Women	Children	Pregnant Women	
New Jersey	Yes	Yes	Yes (Medicaid and CHIP); awaiting approval	Yes (Medicaid and CHIP); awaiting approval	April 1, 2009
New Mexico	Yes	No	Yes (Medicaid); approved	Yes (Medicaid and CHIP); approved	November 1, 2009
New York	Yes	Yes	Yes (Medicaid and CHIP); awaiting approval	Yes (Medicaid); awaiting approval	April 1, 2009
Oklahoma	No	Yes (CHIP unborn child option)	No	No	
Oregon	No	Yes (CHIP unborn child option)	Yes (Medicaid and CHIP); approved	No	
Pennsylvania	Yes	Yes	Yes (Medicaid and CHIP); awaiting approval	Yes (Medicaid); awaiting approval	October 1, 2009
Rhode Island	No	Yes (CHIP unborn child option)	Yes (Medicaid and CHIP); approved[8]	No	July 1, 2009
Tennessee	No	Yes (CHIP unborn child option)	No	No	
Texas	Yes	Yes (CHIP unborn child option)	No[9]	No	
Virginia	Yes	No	Yes (Medicaid); awaiting approval	No	April 1, 2009
Washington	Yes	Yes (Medicaid and CHIP unborn child option)	Yes (Medicaid and CHIP); awaiting approval	Yes (Medicaid); awaiting approval	April 1, 2009
Wisconsin	No	Yes (CHIP unborn child option)	Yes (Medicaid and CHIP); awaiting approval	Yes (Medicaid and CHIP); awaiting approval	October 1, 2009
Wyoming	Yes	Yes	No	No	
Total	**20**	**27**	**20**	**17**	

See sources and table notes on the next page.

Table Sources and Notes

Sources:

For existing coverage: *New Option for States to Provide Federal Funded Medicaid and CHIP Coverage to Additional Immigrant Children and Pregnant Women* (Washington: Kaiser Commission on Medicaid and the Uninsured, July 2009); *Medical Assistance Programs for Immigrants in Various States* (Washington: National Immigration Law Center, February 2010). For coverage under the new option: Families USA tracking efforts. All information is accurate as of March 2010.

* This table includes only states that covered immigrant children or pregnant women prior to CHIPRA enactment and states that are planning to take up the new option to cover legally residing immigrant children or pregnant women. States that did not provide coverage to these groups and do not plan to under the new option are not included.

Notes:

[1] Includes Medicaid or CHIP coverage, prenatal coverage only (through the CHIP unborn child option), or other state programs. In some cases, there were limits on the number of people who could enroll in these forms of coverage.

[2] Colorado passed legislation in 2009 to take up the option for children and pregnant women when state funds became available. Currently, state funding is unavailable.

[3] In Florida, only immigrant children who were enrolled in CHIP as of January 31, 2004, are eligible. A freeze on enrollment of non-federally eligible children has been in effect for several years.

[4] A bill was introduced in the Florida state legislature in February 2010 to expand coverage to legal immigrant children. If enacted, it would go into effect on October 10, 2010.

[5] Maine also plans to submit a state plan amendment for children in CHIP.

[6] Massachusetts also plans to submit a state plan amendment for children in CHIP.

[7] Minnesota passed legislation in 2009 to take up the option for children and pregnant women, effective July 1, 2010. A state plan amendment will be submitted in early 2010.

[8] Rhode Island is not yet enrolling children in the new option.

[9] Texas plans to submit a state plan amendment for children's coverage, effective May 1, 2010.

Conclusion

Forthcoming guidance from CMS will clarify some of the specific policy details about this new option, but the fact that so many states are already taking advantage of it is testimony to the important gaps it fills. This new option gives states an opportunity to correct an inequity that has gone on for far too long. States that are able to take advantage of the new option will make strides toward addressing health disparities, providing essential benefits to children and pregnant women who would otherwise go without.

Endnotes

[1] The CHIPRA provision is often referred to as "ICHIA," which stands for the Immigrant Children's Health Improvement Act, the name of earlier legislative proposals to extend coverage to these children and pregnant women.

[2] This is because federal CHIP law prohibits states from covering those in families with higher incomes unless coverage is also available to families with lower incomes.

[3] See Section 214 (a)(2) of the Children's Health Insurance Program Reauthorization Act of 2009 (H.R. 2, P.L. 11-3).

[4] The term "qualified immigrant" includes lawful permanent residents; refugees, asylees, persons granted withholding of deportation/removal, conditional entry, or paroled into the U.S. for at least one year; Cuban or Haitian entrants; and battered spouses and children with a pending or approved self petition for an immigrant visa, or immigrant visa filed for a spouse or child by a U.S. citizen or LPR, or application for cancellation of removal/suspension of deportation, whose need for benefits has a substantial connection to the battery or cruelty. Parents and/or children of such battered children or spouses are also "qualified." See Table 10, "State-Funded Medical Assistance Programs," in National Immigration Law Center, *Guide to Immigrant Eligibility for Federal Programs – 4th edition* (Los Angeles: National Immigration Law Center, 2002), available online at http://www.nilc.org/pubs/guideupdates/tbl10_state-med-asst_2007-07_2009-03.pdf.

[5] This information was provided by Cindy Mann, Director of the Center on Medicaid and State Operations at CMS, during a public conference call hosted jointly by the Center on Budget & Policy Priorities, the Georgetown Center for Children & Families, and Families USA, on November 16, 2009.

[6] Dana P. Goldman, James P. Smith, and Neeraj Sood, "Legal Status and Health Insurance among Immigrants," *Health Affairs* 24, no. 6 (November/December 2005): 1,640-1,653.

[7] The Congressional Budget Office estimates that lifting the five year bar will cost the federal government $3.9 billion over the 10-year period 2009-2019. Congressional Budget Office, *H.R. 2 Children's Health Insurance Program Reauthorization Act of 2009* (Washington: CBO, February 11, 2009), available online at http://www.cbo.gov/ftpdocs/99xx/doc9985/hr2paygo.pdf.

[8] States are receiving a federal Medicaid matching rate that is at least 6.2 percentage points higher than they would otherwise receive due to a provision in the American Recovery and Reinvestment Act of 2009. This higher matching rate is available until December 31, 2010. As a result of these increases, the enhanced Medicaid matching rate is actually higher than the CHIP matching rate in several states.

[9] States will need to enroll these individuals in their Medicaid and CHIP plans, not state-funded coverage that is different than Medicaid or CHIP.

[10] The base Medicaid matching rate in 2010 is 56.2 percent because of the temporary increase in federal Medicaid funding due to the American Recovery and Reinvestment Act of 2009. That increase is set to expire on December 31, 2010, at which point the base Medicaid matching rate will revert to 50 percent.

[11] Michael C. Lu, Yvonne G. Lin, Noelani M. Prietto, and Thomas J. Garite, "Elimination of Public Funding of Prenatal Care for Undocumented Immigrants in California: A Cost/Benefit Analysis," *American Journal of Obstetrics and Gynecology* 182, part 2, no. 1 (January 2000): 233-239; Leemore Dafny and Jonathon Gruber, "Does Public Insurance Improve the Efficiency of Medical Care? Medicaid Expansion and Child Hospitalizations," *Working Paper 7555* (Cambridge, MA: National Bureau of Economic Research, February 2000), available online at http://www.nber.org/papers/w7555.

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