Report on Health Reform Implementation

What Health Care Reform Means for Immigrants: Comparing the Affordable Care Act and Massachusetts Health Reforms

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Editor's Note: JHPPL *has started an ACA Scholar-Practitioner Network (ASPN). The ASPN assembles people of different backgrounds (practitioners, stakeholders, and researchers) involved in state-level health reform implementation across the United States. The newly developed ASPN website documents ACA implementation research projects to assist policy makers, researchers, and journalists in identifying and integrating scholarly work on state-level implementation of the ACA. If you would like your work included on the ASPN website, please contact web coordinator Phillip Singer at pmsinger@umich.edu. You can visit the site at http://ssascholars.uchicago.edu/jhppl/.*

JHPPL *seeks to bring this important and timely work to the fore in Report on Health Reform Implementation, a recurring special section. The journal will publish essays in this section based on findings that emerge from network participants. Thanks to funding from the Robert Wood Johnson Foundation, all essays in the section are published open access.*
—Colleen M. Grogan

Abstract The 2010 Patient Protection and Affordable Care Act (ACA) was passed to provide more affordable health coverage to Americans beginning in 2014. Modeled after the 2006 Massachusetts health care reform, the ACA includes an individual mandate, Medicaid expansion, and health exchanges through which middle-income individuals can purchase coverage from private insurance companies. However, while the ACA provisions exclude all undocumented and some documented immigrants, Massachusetts uses state and hospital funds to extend coverage to these groups. This article examines the ACA reform using the Massachusetts reform as a comparative case study to outline how citizenship status influences individuals' coverage options under

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both policies. The article then briefly discusses other states that provide coverage to ACA-ineligible immigrants and the implications of uneven ACA implementation for immigrants and citizens nationwide.

Keywords health policy, immigration policy, Massachusetts health reform, ACA, health care access

Introduction

In 2010, US president Barack Obama signed the Patient Protection and Affordable Care Act (ACA)—also known as Obamacare—the federal policy that would make health insurance more affordable for Americans upon implementation in 2014 (Blumberg and Clemans-Cope 2012; Levy 2013; Long, Stockley, and Dahlen 2012). However, the ACA explicitly excludes undocumented immigrants, providing coverage only for US citizens and certain documented immigrants due to 1996 immigration and welfare reforms that limit the public benefits available to those legal permanent residents (LPRs; green card holders) who have been in the United States for fewer than five years.[1] The ACA has also experienced implementation setbacks amid legislative attempts to repeal the law and enrollment difficulties, since all states have not fully complied. These factors have undermined the policy's ability to extend coverage to uninsured Americans. Though the ACA is a federal policy, its legislation was based on health reform initiated in Massachusetts.

In 2006, Massachusetts became the first state to pass comprehensive health reform to provide coverage to most of its residents and contain health care costs (Levy 2013; Long and Masi 2009; Wilson 2008). State policy makers and laypersons lauded the reform, legislatively known as chapter 58: uninsurance fell to 3.1 percent, and by 2011, most residents had increased access to care (Long, Goin, and Lynch 2013; BCBS 2013). These statistics exclude *ineligible* individuals such as undocumented immigrants, who made up an estimated 2.4 percent of the state population as of 2010 (Passell and Cohn 2011; McClellan 2013). However, under chapter 58, immigrants of different citizenship statuses could apply for and receive state-funded health coverage.[2] ACA implementation in Massachusetts has

1. These were the Personal Responsibility and Work Opportunity Act (PRWOA) and Illegal Immigration Reform and Immigrant Responsibility Act (IIRIRA). These reforms also made ineligible undocumented immigrants and student or work visa holders. I refer to LPRs in the United States for less than five years as short-term LPRs and LPRs in the United States for five or more years as long-term LPRs.

2. *Citizenship status* and *documentation status* are often used interchangeably. I use *citizenship status* in this article to illustrate that citizens are entitled to all benefits, while immigrants of different documentation statuses are typically excluded.

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transformed chapter 58, altering how individuals of all citizenship statuses, especially those with subsidized plans, apply for coverage. Given the 1996 federal restrictions and Massachusetts's compliance with the ACA, many immigrants will not benefit from federally funded ACA provisions (Capps and Fix 2013; Sommers 2013).

Immigrants make up 15 percent of the Massachusetts population and 13 percent of the US population, and a sizable demographic is therefore legally excluded from the ACA (Capps and Fix 2013; US Census 2010). In this article, I examine how citizenship status influences the types of health coverage available to individuals under the ACA, using Massachusetts as a comparative case study. Various studies have explored key differences between these two reforms, but very few have comprehensively outlined the ways in which citizenship status determines one's coverage options under each reform (Blumberg and Clemans-Cope 2012; Patel and McDonough 2010; Seifert and Cohen 2010). I discuss how the lack of policy transparency in chapter 58 allowed Massachusetts to extend coverage to ineligible immigrants without public opposition and amid federal restrictions to maintain these options for immigrants under the ACA. I conclude with a brief discussion of other states that include ACA-ineligible immigrants and the implications of imperfect ACA implementation across the country, given state variation in ACA compliance.

The ACA and Coverage for Immigrants

By policy design, the ACA legally excludes undocumented immigrants, student and employment visa holders, and short-term LPRs because of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWOA) (Pub. L. 104-193, 110 Stat. 2105) and the Illegal Immigration Reform and Immigrant Responsibility Act of 1996 (IIRIRA) (Pub. L. 104-208, 110 Stat. 3009) (Capps and Fix 2013; Lee 2013; Zuckerman, Waidmann, and Lawton 2011).[3] These laws sought to curb undocumented immigration in the 1990s by reducing immigrants' access to public benefits and making it difficult for LPRs to naturalize if they used public benefits (Park 2011). The interrelationship between the ACA and these

3. President Obama announced the Deferred Action for Childhood Arrivals (DACA) program in June 2012, which allowed undocumented young adults brought to the United States as children to receive temporary relief from deportation. DACA recipients can receive work authorization but do not have LPR status and cannot obtain citizenship. DACA recipients are ineligible for ACA provisions unless they are under age eighteen and low income, which would make them eligible for the Children's Health Insurance Program (CHIP) through the Medicaid expansion (Wong et al. 2013). DACA recipients are now eligible for state-sponsored subsidized coverage in Massachusetts and California.

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1996 laws systematically leaves most immigrants without access to health coverage while extending coverage to most citizens (Marrow and Joseph 2015). The primary option for undocumented immigrants is to purchase expensive unsubsidized private health insurance directly from insurance carriers. Short-term LPRs have limited options. They can purchase private health insurance through the federal and state exchanges if their incomes are less than 400 percent of the federal poverty level (FPL) or directly from insurance carriers, regardless of income. However, immigrants with temporary protected status—refugees or asylees—are eligible for all types of federally subsidized plans and participation in the exchanges for their first seven years in the country. Work and student visa holders may participate in the exchanges but are ineligible for Medicaid (see the last column in table 1 for immigrant coverage options).

Massachusetts Health Reform and Coverage for Immigrants

Although the picture seems bleak for many immigrants to access health insurance under the ACA, some states, including Massachusetts, have incorporated this population in their health coverage systems. Chapter 58 has reduced the number of uninsured Massachusetts residents, but an estimated 3.1 percent remain uninsured due to having unstable employment or fluctuating income (BCBS 2013; Pryor and Cohen 2009). Among this group are low- to middle-income citizens and long-term LPRs who experience an insured-uninsured cycle created by shifts in their income eligibility for subsidized coverage and their ability to pay for insurance (Long, Goin, and Lynch 2013). Undocumented immigrants are also likely to remain uninsured, although estimates of this population are difficult to obtain (BCBS 2013; Pryor and Cohen 2009). The state has also struggled to lower health care costs and has implemented additional policies for this purpose (Long and Masi 2009; McDonough et al. 2011).

Scholars, lawmakers, and health care professionals have applauded the policy as an overall success. But many have questioned the generalizability of Massachusetts to the nation, given the state's demographics (Dennis et al. 2013; Levy 2013; Patel and McDonough 2010). With 6.6 million people, the state had low uninsurance rates before chapter 58, meaning that fewer residents needed coverage compared to the national population. Massachusetts residents' higher education and income levels also created an adequate tax base for establishing state-subsidized coverage. However, with an immigrant population larger than the national average and the state's ability to extend coverage to its immigrants despite

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Table 1 Citizenship Status and Coverage in Massachusetts prior to ACA Implementation and across the United States after Implementation

Coverage Based on Citizenship Status	MA: Ch. 58 (Pre-ACA)	MA: Post–ACA Implementation	ACA in Most States
Undocumented	Yes: HSN if income eligible, exchange	Yes: HSN if income eligible No: exchange	No expansion
Undocumented deferred action recipients (DACA/ Dreamers)	Yes: HSN if income eligible, exchange	Yes: HSN if income eligible No: exchange	Yes: Medicaid expansion if income eligible and under age 18 No: if over age 18
Temporary protected/ special status: refugees, asylees	Yes: HSN, exchange, MassHealth, CommCare if income eligible	Yes: HSN, exchange, MassHealth Standard/ CarePlus if income eligible	Eligible for all
Visas: work, student	Yes: HSN if income eligible, private via exchange No: MassHealth, CommCare	Yes: HSN if income eligible, private via exchange No: MassHealth Standard/ Care Plus	Yes: Private via exchange No: Medicaid
Legal permanent residents (<5 years in US)	Yes: HSN, CommCare if income eligible, private via exchange/ carrier if >300 percent FPL No: MassHealth	Yes: HSN, ConnectorCare if income eligible, private via exchange/carrier if >300 percent FPL No: MassHealth	Yes: private via exchange if income < 400 percent FPL No: Medicaid
Legal permanent residents (>5 years in US)	Eligible for all	Eligible for all	Eligible for all
Naturalized and US-born citizens	Eligible for all	Eligible for all	Eligible for all

Notes: HSN = Health Safety Net; CommCare = Commonwealth Care; FPL = Federal poverty level

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federal restrictions, Massachusetts provides a model for other states with ACA-ineligible immigrants (Wilson 2008; Zuckerman, Waidmann, and Lawton 2011).

Immigrants' Health Coverage under Chapter 58 (Pre-ACA)

Although most Massachusetts residents received coverage under chapter 58, the state included provisions for un(der)insured individuals such as immigrants who were ineligible for state and federally subsidized coverage or for low-income individuals without adequate coverage from other qualified health plans (Wilson 2008). This meant that Massachusetts residents of *any* citizenship status with income eligibility could apply for some type of health coverage. However, those coverage options were delimited by citizenship status.

Many immigrants received coverage through the Health Safety Net (HSN) program, which was funded by the Health Safety Net Trust Fund. Most of this fund comes from a state tax that was imposed on acute care hospital revenues, was allocated to a pooled fund, and then was redistributed to acute hospitals and community health centers that primarily served un(der)insured populations (Wilson 2008).[4] Other sources for the HSN Trust Fund were insurers and the Commonwealth General Fund, which generated revenue from income taxes, sales tax, and other taxes (MMPI 2012; Massachusetts Department of Revenue 2013).[5] These property taxes along with the hospital taxes—which were passed on to state residents through higher insurance premiums and health care costs—represented ways that taxpayers indirectly contributed to the HSN program. Hacker (2002) describes these as "hidden taxes" in his scholarship on the politics of private benefits.

HSN was not insurance but instead was a coverage program that provided preventive and some specialty services (i.e., prescriptions, psychiatric services) to un(der)insured adults of any citizenship status whose income was less than 400 percent FPL (Community Resources Information 2013; Cunha 2013).[6] There was no premium, and co-payments were small, which is why the program was known as Free Care before chapter 58 (Cunha 2013). HSN coverage was accepted at forty-nine community

4. This amount was $320 million in 2013 (MMPI 2012).

5. The amount appropriated from the Commonwealth General Fund via the Commonwealth Care Trust Fund was $30 million in 2013 (MMPI 2012).

6. There were three levels of HSN coverage: (1) HSN Primary—uninsured patients with family income of 0 percent to 200 percent FPL; (2) HSN Secondary—insured patients with family income of 0 percent to 200 percent FPL; (3) HSN Partial—patients with family income of 201 percent to 400 percent FPL (Community Resources Information 2013).

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health centers with more than 120 sites in the state, but treatment received from private physicians and specialty care groups was not covered (Community Resources Information 2013).

Since there were more uninsured patients under Free Care, acute hospitals allocated more tax revenue to the pooled fund. However, since chapter 58 implementation, there have been fewer uninsured individuals, which means the shortfall produced by the "new" HSN Trust Fund was absorbed by hospitals (Massachusetts Health Connector 2012). This reduction yielded a smaller budget, generating less revenue for HSN health care facilities to care for the remaining un(der)insured (Wilson 2008).

The next coverage option available for eligible *documented* immigrants was MassHealth, the state's Medicaid program, if documented immigrants had incomes of less than 300 percent FPL (Executive Office of Health and Human Services 2013b). Because Medicaid is a federal program, immigrant Medicaid recipients had to be long-term LPRs, have temporary protected status, or be naturalized citizens. Under chapter 58, there were seven types of MassHealth coverage (Executive Office of Health and Human Services 2013b).[7] MassHealth Standard, the most comprehensive, provided preventive care, inpatient hospital services, medical services (e.g., lab tests), prescriptions, and behavioral health services, among others (Executive Office of Health and Human Services 2013b). Income eligibility for MassHealth Standard varied depending on the recipient of the coverage: (1) 200 percent FPL for pregnant women and children under age one, (2) 150 percent FPL for children ages one to eighteen, and (3) 133 percent FPL for parents of children under age nineteen (Executive Office of Health and Human Services 2013b). MassHealth could be used anywhere Medicaid was accepted.

The next type of publicly subsidized care available for *documented* immigrants and US citizens was Commonwealth Care (CommCare).[8] This insurance was for individuals and families whose incomes were too high to qualify for MassHealth but too low to afford private insurance, falling between 0 percent and 300 percent FPL (Health Connector Commonwealth Care 2012). Because Massachusetts funded CommCare, short-term LPRs were eligible. The federal restriction that prohibited this group from receiving Medicaid did not make them ineligible for CommCare. Individuals with CommCare could use the state's exchange, known as the Connector, to select one of the available private insurance plans to manage their health care needs. Massachusetts paid the total costs of health

7. The different types of MassHealth were tied to different income eligibility cutoffs from 0 percent to greater than 300 percent FPL.

8. This should not be confused with the Commonwealth Fund used to fund HSN.

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insurance for CommCare members with incomes less than 150 percent FPL and subsidized premium costs for CommCare members with incomes between 150 percent and 300 percent FPL. The services available through CommCare varied depending on the private insurance plan patients selected, and coverage could be used anywhere that accepted the patient's CommCare plan.

Aside from partially or fully subsidized options, LPRs, documented immigrants with student visas, and citizens could purchase private health insurance from the Connector. All individuals who were ineligible for subsidized coverage through MassHealth or the Connector could purchase private insurance directly from insurance companies, and this included undocumented immigrants. Remaining immigrant individuals could have received employer-sponsored health insurance. Although some immigrants worked for companies with private health insurance plans, they were likely to have had higher education levels and were documented through employer-sponsored work visas, green cards, or as naturalized citizens (see the second column in table 1).

Before October 1, 2013, to receive HSN, MassHealth, or CommCare, individuals seeking subsidized coverage applied to MassHealth, the state's health insurance program, which served as a clearinghouse to determine applicants' eligibility. Once an application was submitted with proof of state residency, income, and citizenship status (for eligible state residents), MassHealth employees screened materials and sorted applicants into the appropriate category.[9]

Immigrants' Health Coverage after the ACA and amid Federal Exclusions

When the ACA was implemented in 2014, Massachusetts had had health reform for seven years and was consequently more prepared for implementation than other states. To fully comply with the ACA, the chapter 58 reform underwent changes, some of which influenced how Massachusetts immigrants and citizens accessed coverage in 2014 (Massachusetts Health Connector 2013; Seifert and Cohen 2010). Aware of the ACA exclusions for undocumented and documented immigrants, Massachusetts policy makers took steps to continue providing the same coverage options for its residents, but doing so with minimal transparency for the general public (see the third column in table 1). While state residents were aware that Massachusetts

9. For more on immigrants' difficulties with the application process, see Joseph 2013.

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would comply with the ACA, clear and specific information about all the changes that would occur was not readily available (Joseph 2013).

On October 1, 2013, the application process for the state's partially and fully subsidized plans changed. All applicants to such plans had to apply through the new Commonwealth Connector website or submit paper applications to the Commonwealth Connector or MassHealth office (Executive Office of Health and Human Services 2015). Since then, the Commonwealth Connector (now known as the Massachusetts Health Connector) rather than MassHealth, serves as the clearinghouse for sorting applicants into health plans based on income and citizenship status (see fig. 1).

Because the HSN program was not federally funded, it has remained intact and still provides coverage for un(der)insured individuals, some of whom are undocumented, since that population remains excluded from the federal Medicaid expansion and participation in the Connector. Just as under chapter 58, HSN funding primarily comes from hospitals, allowing it to remain out of the public spotlight. On December 31, 2013, two major changes occurred. First, MassHealth was restructured to accommodate the federal Medicaid expansion. There are two types of MassHealth: MassHealth Standard, for those eligible under chapter 58, and MassHealth CarePlus, for those newly eligible with incomes of up to 133 percent FPL under the ACA (Executive Office of Health and Human Services 2015).[10] This change has affected previous CommCare recipients with incomes of up to 133 percent FPL who were transferred to MassHealth CarePlus. Both MassHealth plans provide the same comprehensive services as under chapter 58.

Given the federal restriction on Medicaid for short-term LPRs, previous CommCare recipients in this category are now ineligible for MassHealth CarePlus. The second change, which applies to short-term LPRs, was the creation of a program called ConnectorCare, which provides coverage to adult citizens and eligible noncitizens (such as short-term LPRs) with incomes of no more than 300 percent FPL (Executive Office of Health and Human Services 2015). Citizens and qualified immigrants (long-term LPRs) with an income of 133 percent to 300 percent FPL and "lawfully present immigrants" ineligible for MassHealth (i.e., short-term LPRs) with incomes of 0 percent to 300 percent FPL are eligible for federal and state

10. The other five MassHealth programs as they existed under chapter 58 were discontinued. However, under the ACA, some programs were given new names and provide coverage for special populations (i.e., pregnant women, disabled, HIV positive). Individuals eligible for MassHealth Standard and MassHealth Care Plus may or may not be eligible for these special MassHealth Programs. For more, see the MassHealth member booklet (Executive Office of Health and Human Services 2015).

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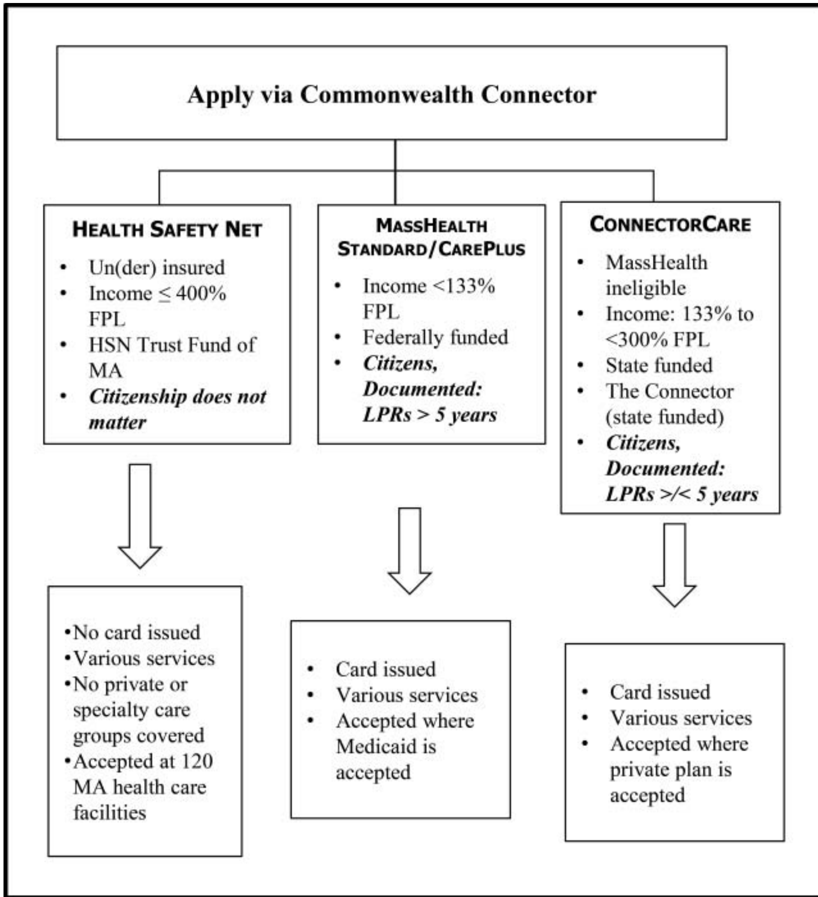

Figure 1 Public Coverage Options in Massachusetts after ACA Implementation

subsidies under the ACA (Executive Office of Health and Human Services 2013a).[11] Furthermore, long-term LPRs with incomes between 300 percent and 400 percent FPL are eligible for federal tax credits to purchase insurance in the exchange (Executive Office of Health and Human Services 2013b). Massachusetts supplements federal funds with state funds to reduce premiums and cost sharing under ConnectorCare. This program has many of the same benefits as chapter 58's Commonwealth Care. Immigrants with temporary protected status are eligible to apply for all types of coverage depending on income eligibility. Finally, immigrants with

11. Short-term LPRs can receive state subsidies for ConnectorCare only.

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student visas can purchase private coverage through the Connector or directly from private companies. Just as under chapter 58, individuals ineligible for subsidized care due to income or citizenship status have the option of purchasing private insurance directly from providers.

Policy Implications for Massachusetts and the Nation

Massachusetts has chosen not to exclude immigrants from health coverage, as the federal government and many other states are doing under the ACA. Under chapter 58 and post-ACA implementation, health coverage is more available to Massachusetts immigrants, although citizenship status influences which type of coverage immigrants are eligible for, given existing federal restrictions. Undocumented immigrants are excluded from the exchanges and Medicaid programs in the state. However, all income-eligible immigrants can apply for the Health Safety Net program, which legislators established to provide coverage to the remaining uninsured after the passage of chapter 58. The state also still provides subsidized coverage to short-term LPRs.

By policy design, Massachusetts appears to have based its reform on income, insurance status, and state residency, including federally ineligible immigrants as part of its civic community. This inclusion symbolizes the conception of local "inhabitance," where residence, not legal citizenship, determines health coverage eligibility (de Graauw 2012; Ridgley 2008). Creating and funding HSN with hidden taxes from hospital revenue likely made it easier for lawmakers to pass legislation for a program that indirectly benefited undocumented immigrants (Hacker 2002). Furthermore, HSN annual reports include user demographics disaggregated by income, gender, and family size but *not* by citizenship status, illustrating another strategic decision to include undocumented immigrants with other low-income and underinsured state residents (Massachusetts Division of Health Care Finance and Policy 2012).

The Massachusetts case is informative for understanding how state and federal reforms can provide coverage to immigrant and other vulnerable populations. First, various chapter 58 components (i.e., Medicaid Expansion, health exchange) were used to draft the ACA and were critical for incorporating low-income citizens, many of whom were previously uninsured, and ethno-racial minorities into the health care system. Second, the state's vague policy design allowed it to provide coverage to immigrants excluded from federal programs under chapter 58 and the ACA, despite federal restrictions.

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Finally, Massachusetts exemplifies the costs associated with health reform and how immigrants' coverage is especially vulnerable to budget cuts. Although chapter 58 was considered a success, cost containment remains a significant issue, and Massachusetts has the nation's highest health care costs (Song and Landon 2012). Chapter 58's lack of transparency allows the state to alter coverage for certain populations without public scrutiny, as most state residents are uninvolved in the health (or other) reform policy-writing process. Because HSN is funded through hidden taxes, the state can and has reduced its HSN allocation when it has been fiscally necessary. And when the 2008 recession affected the state budget, Massachusetts shifted short-term LPRs previously covered under Commonwealth Care to less expensive and lower-quality insurance, which disrupted those patients' health care access (Long and Masi 2009). Some patients were unaware of such changes until they went for medical appointments and learned their coverage was no longer accepted (Joseph 2013).[12]

Despite such drawbacks, Massachusetts provides a model for including immigrants that other states can learn from and likely improve upon. A program like HSN could incorporate undocumented immigrants into the health care system by providing preventive care and could reduce health care costs associated with emergency room admissions, which are high among this population (Warner 2012). A state-funded program like ConnectorCare would provide coverage to eligible documented and tax-paying immigrants who are lawfully in the country.

Other states have also made efforts to extend health coverage to immigrants in their jurisdictions (Marrow and Joseph 2015). One such state is Vermont, which implemented health reform that consisted of a single-payer, publicly financed, and universal health care system called Green Mountain Care (Grubb 2013). Vermont's reform also included a Medicaid expansion, established a state health exchange, and used state funds to insure the few undocumented immigrants living there (Gram 2011).

California is important to highlight as one of the country's largest states with a sizable immigrant population. California has used state funds to provide limited Medicaid coverage for emergencies and pregnancy-related issues to individuals regardless of citizenship status (Brindis et al. 2014). At the county level, the Healthy San Francisco program provides primary health care to *any* local resident with an income of less than 500 percent FPL and who does not qualify for other types of federal or state public coverage (Dow, Dube, and Colla 2009; Katz 2008; Marrow 2012). Other

12. In 2012, Health Law Advocates successfully sued the state, arguing it was unconstitutional to discriminate against these immigrants. The state had to reinstate Commonwealth Care to LPRs who lost their coverage (Health Law Advocates 2012).

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local and state programs allow low-income individuals of any citizenship status to temporarily enroll in Medi-Cal, the state's Medicaid program, while their formal application is reviewed (Brindis et al. 2014). Under the ACA, California has used its own funds to extend Medicaid coverage to Deferred Action for Childhood Arrivals (DACA)–eligible individuals, who are ineligible at the federal level (Brindis et al. 2014). A Democratic state senator also proposed the Health for All Act to expand Medi-Cal coverage to undocumented immigrants and establish a new exchange where the undocumented can purchase coverage (May 2014). If this bill were passed, California would be the first state to create a health exchange specifically for this group.

As socially progressive states, Massachusetts, Vermont, and California have fully complied with ACA implementation and expanded (some) coverage to ineligible immigrants. These states' use of nonfederal funds may provide models and policy strategies for other states in light of federal restrictions. Income-eligible immigrants residing in these states have coverage options that would otherwise not be available.

In the absence of federal policy reform to revise the 1996 IIRIRA and PRWOA laws and the ACA, or immigration reform to adjust the citizenship status of ACA-ineligible immigrants, this population will remain excluded (Capps and Fix 2013; Marrow and Joseph 2015; Sommers 2013). Given the current political climate, the likelihood of these policy changes occurring is minimal. The imperfect implementation of the ACA up to this point also has significant consequences for citizens based on their state of residence. Both citizens and (some) immigrants in non-ACA-compliant states will have less access to coverage than their counterparts in ACA-compliant states. These differences will yield further disparities in health care access across the country, and only time will tell how this process will unfold.

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