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HEALTH REFORM ISSUE BRIEF

IMMIGRANTS AND THE AFFORDABLE CARE ACT

**Overview**

This issue brief will focus on various Affordable Care Act (ACA) provisions and their impact on the immigrant population. The ACA expands access to public and private health insurance by (1) broadening eligibility for low-income individuals to participate in the Medicaid program; (2) establishing state-based marketplaces called exchanges where people can compare and purchase private health insurance; and (3) providing federal subsidies to eligible individuals to make health insurance offered through exchanges more affordable. In the ACA, immigrants are referred to as “lawfully present”[[1]](#endnote-1) or “not lawfully present.”[[2]](#endnote-2) Lawfully present immigrants include legal permanent residents, asylees, refugees, and temporary workers,[[3]](#endnote-3) and are subject to different aspects of the law depending on how long they have resided in the United States. “Not lawfully present” immigrants are undocumented individuals and do not qualify for access to health insurance under the ACA. State health departments and their partner community-based organizations are often safety-net providers to vulnerable populations like the immigrant community. As insurance access is vital for people living with HIV/AIDS and viral hepatitis to be linked to care, state health departments should be aware of how immigrants will be treated under the ACA. For questions on immigrants and the ACA, contact Amy Killelea.

**Data on Immigrants Living in the U.S.**

*Population and income*

* Approximately 40 million immigrants reside in the U.S., making up 13 percent of the total population.[[4]](#endnote-4) Among all immigrants, approximately 11 million are undocumented as of January 2013.[[5]](#endnote-5)
* Approximately 6 percent of non-elderly adults in the U.S. are undocumented or recent lawfully present immigrants (i.e., five years residency or less). Among *low-income* non-elderly adults, however, 10 percent are undocumented or recent lawfully present immigrants.[[6]](#endnote-6)
* Recent lawfully present immigrants are at generally lower income levels than other immigrants. 49.9 percent are below 138 percent of the Federal Poverty Line (FPL), compared to 41.9 percent of immigrants with more than five years residency and 27.4 percent of U.S-born citizens.[[7]](#endnote-7)

*Access to health care*

* Immigrants are three times more likely than U.S.-born citizens to be uninsured.[[8]](#endnote-8) Around 48 million people were uninsured in 2011, 20 percent of whom were immigrants.[[9]](#endnote-9)
* Among low-income uninsured non-elderly adults, 17 percent are undocumented or recent lawfully present immigrants.[[10]](#endnote-10)
* Immigrants are less likely than citizens to have a usual source of care (64 vs. 87 percent) or receive preventive services (71 vs. 87 percent).[[11]](#endnote-11)

*HIV/AIDS and viral hepatitis*

* More than 1.1 million people in the U.S. are living with HIV/AIDS.[[12]](#endnote-12) The percentage of those who are immigrants is unclear.
* The Hispanic/Latino community, which is disproportionately affected by HIV/AIDS, accounted for 20 percent of new HIV infections in the U.S. in 2009.[[13]](#endnote-13) In 2011, approximately 11,032 Hispanic/Latino adults and adolescents in the U.S. were diagnosed with HIV. Of those, 6,780 (61 percent) were born outside the U.S.[[14]](#endnote-14)
* Around 5.3 million people are living with hepatitis B or C in the U.S. The percentage of those who are immigrants is unclear, but approximately 54,000 people with viral hepatitis immigrate to the U.S. annually.[[15]](#endnote-15)

**ACA Provisions Affecting Immigrants**

Several major ACA provisions will have a significant impact on the immigrant population:

*Medicaid expansion*

* Starting in 2014, U.S. citizens and lawfully present immigrants residing in the U.S. for more than five years will be eligible for Medicaid if they are at or below 138 percent of the FPL.[[16]](#endnote-16)
* Most lawfully present immigrants residing in the U.S. for five years or less will not be eligible for Medicaid, regardless of income level, due to existing rules under the Personal Responsibility and Work Opportunity Reconciliation Act of 1996.[[17]](#endnote-17) However, under a 1980 law, refugees can be enrolled in Medicaid immediately upon arrival and can reapply after eight months.[[18]](#endnote-18)
* Undocumented immigrants continue to be ineligible for the Medicaid program and will not be eligible for the program’s expansion.[[19]](#endnote-19)
* In 2011, the Supreme Court ruled that states have the option of not expanding Medicaid.[[20]](#endnote-20) Those states will continue to set eligibility thresholds and use state funds to cover services for certain populations.[[21]](#endnote-21)

*Tax credits and cost sharing for exchange plans*

* Starting in 2014, citizens and lawfully present immigrants above 138 percent of the FPL may purchase a qualified private health plan in an “exchange.”[[22]](#endnote-22)
* People under an exchange with income between 100 and 400 percent of the FPL are eligible for federal tax credits to help offset the cost of insurance premiums.[[23]](#endnote-23)
* People under an exchange with income between 100 and 250 percent may receive cost-sharing subsidies, which allow individuals to enroll in plans with a higher actuarial value (i.e., plans that cover a larger percent of eligible services).[[24]](#endnote-24) For more details on the ACA’s tax credit and cost-sharing provisions, see [this NASTAD issue brief](http://www.nastad.org/docs/HCA-Affordability-Brief-FINAL-February-2013.pdf)**.**
* All lawfully present immigrants will be eligible to participate in the exchange.[[25]](#endnote-25) Recent lawfully present immigrants (i.e.,five years residency or less) will be eligible for premium tax credits and cost-sharing, even if they are below 100 percent FPL.[[26]](#endnote-26)
* Undocumented immigrants will not be eligible for the exchange or the accompanying tax credits and cost sharing. Undocumented immigrants will also not be subject to the monetary penalty for not having health insurance.[[27]](#endnote-27)

*High risk pools*

* Until exchanges are operational in 2014, all citizens and lawfully present immigrants (including those with five years of residency or less) may participate in Pre-existing Condition Insurance Plans (PCIPs).[[28]](#endnote-28)
* Among the 35 states that already operate high-risk pools prior to ACA, most require participants to be “lawfully present.”[[29]](#endnote-29)

*Adjusted facility payments for safety net entities*

* Federally Qualified Health Centers (FQHCs), which provide primary and preventative health care services to underserved communities, will receive $11 billion in additional funding through 2020.[[30]](#endnote-30)
* Federal payments to Disproportionate Share Hospitals (DSH), which serve a significantly disproportionate share of low-income patients, will decrease by $14.1 billion from 2015 to 2019.[[31]](#endnote-31)

*Immigration status verification*

* In order to determine eligibility for the exchange and Medicaid, all enrollees must provide their immigration status.[[32]](#endnote-32) Name, social security number, and the date of birth will be used to verify citizenship.[[33]](#endnote-33)

*Provisions intended to reduce ethnic disparities*

* State and local government agencies may receive “Community Transformation Grants” to implement preventive health activities to reduce chronic disease rates and health disparities among populations.[[34]](#endnote-34)
* All plans participating in the exchanges must have “culturally and linguistically appropriate” information available.[[35]](#endnote-35)

**Summary of ACA Provision Eligibility by Immigration Status**

|  |  |  |  |
| --- | --- | --- | --- |
| Immigration Status |  | Medicaid Expansion | Insurance Exchange |
|  | *If state opts to expand* | *Premium tax credit* | *Cost-sharing subsidy* |
| U.S. Citizen  | Eligible up to 138% of the FPL | Eligible\* (if 100 - 400% of the FPL) | Eligible\* (if 100-250% of the FPL) |
| Lawfully present, more than five years | Eligible up to 138% of the FPL | Eligible\* (if 100 - 400% of the FPL) | Eligible\* (if 100 - 250% of the FPL) |
| Lawfully present, five years or less | Not eligible | Eligible (up to 400% of the FPL) | Eligible (up to 250% of the FPL) |
| Undocumented (including individuals brought to the U.S. as children) | Not eligible | Not eligible | Not eligible |

 \*if not eligible for Medicaid

**Immigration Reform and Existing Policies that Affect Health Care Access**

Even as states prepare for ACA implementation, Congress and President Obama are discussing comprehensive immigration reform that could potentially affect health insurance coverage for immigrants. A comprehensive immigrantion plan that includes health insurance could eventually result in 7 million additional people gaining access to insurance under the ACA.[[36]](#endnote-36)

*Proposed immigration reform bill*

* As of April 2013, Congress is considering a bipartisan bill that proposes a path to citizenship for 11 million undocumented immigrants, who would qualify as Registered Provisional Immigrants (RPI) under the law.[[37]](#endnote-37)
* RPIs would have “lawfully present” status, but not be eligible for any ACA provisions – including Medicaid expansion and exchanges – until they are eligible to apply for a green card after 10 years.[[38]](#endnote-38)

*Existing policies*

* One major Obama Administration policy that has already affected access to health care for immigrants is the Center for Medicare and Medicaid’s (CMS)

interpretation of the Deferred Action for Childhood Arrivals (DACA) policy, established in June 2012.

* Under DACA, the government can defer deportation action against certain undocumented immigrants who were brought to the U.S. as children.[[39]](#endnote-39)
* Individuals granted deferred action have traditionally been categorized as “lawfully present” and therefore would be eligible for public benefits.[[40]](#endnote-40) However, CMS clarified in August 2012 that for the purposes of health reform, DACA-eligible individuals would not be eligible for Medicaid and the Children’s Health Insurance Program (CHIP);[[41]](#endnote-41) pre-existing condition insurance plans;[[42]](#endnote-42) or private insurance under the exchange.[[43]](#endnote-43)
* The Obama Administration has changed its policy of prohibiting entry into the U.S. for persons living with HIV. In 2009, the Centers for Disease Control and Prevention (CDC) removed HIV from the definition of “communicable disease of public health significance.” Individuals living with those diseases are barred from entering the U.S. under the Immigration and Nationality Act.[[44]](#endnote-44)

**Case Studies: Mixed-Status Families under the ACA**

Families with some members who are citizens, some who are legally present immigrants, and/or some who are undocumented may find it especially difficult to navigate ACA eligibility rules. Consider two hypothetical families:

*Family 1 (California)*

* Miguel, 50, and Sofia, 45, are an undocumented husband and wife who came with their son Jon, 22, to the U.S. twenty years ago, settling in California. Their daughter Julia, 18, was born in California. Jon is living with HIV. Sofia and the children are currently covered as dependents of Miguel, who receives health insurance through his employer, a small business. The business, however, is considering ceasing health coverage due to rising health care costs.
* Miguel, Sofia, and John will not have coverage options if their employer decides to stop providing coverage. Under the ACA, as undocumented immigrants, they are not eligible for health insurance plans under an exchange or Medicaid, regardless of their income.
* Jon has requested deferred deportation under the DACA policy, since he was brought to the U.S. as a child. Jon’s HIV medication is covered through his father Miguel’s employer-based health insurance plan. If Miguel’s employer ceases to provide health insurance, Jon and his parents would be ineligible for health coverage. Despite his undocumented status, Jon may sign up for California’s AIDS Drug Assistance Program (ADAP) because he currently makes less than $50,000 (447 percent of the FPL), and because ADAP does not have immigration eligibility requirements.
* Because California has chosen to expand its Medicaid program (known as MediCal), Julia, as a U.S. citizen, is now eligible for the program as a childless adult whose income is less than 138 percent of the FPL. Julia fears that signing up for coverage may expose her undocumented parents to risk of deportation.[[45]](#endnote-45) MediCal has beta-tested its online MediCal and exchange portal with a range of immigrant families to ensure that ineligible family members are not put as risk.[[46]](#endnote-46)

**Family 1 (California)**

**Miguel, age 50**

* Undocumented immigrant
* **Not eligible** for Medicaid, exchange
* Fears deportation risk if daughter Julia signs up for Medicaid

**Sofia, age 45**

* Undocumented immigrant
* **Not eligible** for Medicaid, exchange
* Fears deportation risk if daughter Julia signs up for Medicaid

**Jon, age 22**

* Undocumented immigrant *living with HIV*
* **Eligible** for DACA, which delays deportation but precludes ACA benefits
* **Eligible** for drug assistance under ADAP because <447% FPL

**Julia, age 18**

* U.S.-born citizen
* **Eligible** for Medicaid, but not exchange because <138% FPL
* Must verify status in Medicaid application

*Family 2 (North Carolina)*

* Robert, 35, is a lawfully present resident living with HIV who has been in the U.S. for six years. One year ago, his wife Jane, 32, and their children Michael, 10, and Lydia, 8, came to the U.S. unlawfully. Jane is also living with HIV. Robert’s employer does not offer health coverage, but under the ACA, he is newly eligible for private insurance under the exchange and accompanying tax credits. However, the rest of his family is not eligible because they are not lawfully present.
* Robert, the sole income-earner, makes $35,325, which is 150 percent of the FPL for a family of four. To determine his level of tax credit eligibility, he must calculate his income *without* taking into account the three members of his family who are not lawfully present. To do this, he has to multiply his income ($32,325) by the following formula: poverty line for his family size subtracting the number of undocumented members *divided by* poverty line for his family size including the number of undocumented members.[[47]](#endnote-47) This works out to $35,325 x ($11,490 / $23,550) = $17,235. That number is 150 percent of the FPL for a household of one. At that level, he must contribute 4 percent of his income to his monthly premium, and the tax credit will cover the rest. Furthermore, 150 percent FPL makes him eligible for the cost-sharing subsidy, so he can sign up for a health plan with 94 percent actuarial value.
* Because he is below North Carolina’s 300 percent of FPL eligibility limit, Robert will qualify for ADAP to cover the portion of his new health plan costs that is not covered by the federal subsidies. At his $17,235 income level, ADAP will cover Robert’s annual premium (approximately $700) for the second-lowest cost plan in North Carolina’s federally-run health insurance exchange.
* Even though Jane has HIV, a pre-existing condition, she is not eligible for North Carolina’s state high-risk pool because she is not lawfully present. Furthermore, she will not be eligible for North Carolina’s transitional pre-existing condition insurance plan or the federally-run exchange. North Carolina has chosen not to expand its Medicaid program, but like many other states its existing program covers children under the Children’s Health Insurance Program (CHIP) for families up to 200 percent of the FPL. However, because North Carolina’s Medicaid and CHIP programs require eligible participants to be lawfully present, Michael and Lydia cannot participate.

**Family 2 (North Carolina)**

**Robert, age 35**

* Lawfully present immigrant, six years of residence
* *Living with HIV*
* **Eligible** for Medicaid, exchange tax credits and cost-sharing

**Jane, age 32**

* Undocumented immigrant *living with HIV*
* **Not eligible** for state high-risk pool, pre-existing condition insurance plan or exchange

**Michael, age 10**

* Undocumented immigrant
* **Not eligible** for CHIP

**Lydia, age 8**

* Undocumented immigrant
* **Not eligible** for CHIP

Highlighted section is amount covered by ADAP

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | Income (individual) | Second Lowest Cost Silver Level Plan Premium  | Individual Minimum Contribution | Federal Premium Tax Credit |
|  | **Annual** | **Monthly** | **Annual** | **Monthly** | **Annual** | **Monthly** | **Annual** | **Monthly** |
| (Robert)150% FPL | $17,235 | $1,436.25 | $4,500 | $375 | $689.40 | $57.45 | $3,810.60 | $317.55 |

**Potential Implications for State Health Departments**

How states implement the ACA will affect how their immigrant populations have access to health insurance and ultimately receive care.

* ***How will ACA affect the mix of clients that state health departments and their community partners serve?***

A significant portion of uninsured and underinsured clients currently utilizing health department services – including lawfully present immigrants – may qualify for the Medicaid expansion and exchange coverage in 2014. However, undocumented immigrants who do not qualify for ACA benefits may continue to rely on emergency rooms and community-based organizations for care.[[48]](#endnote-48) Furthermore, immigrants are generally less likely to obtain needed medical services than the general population, and are also more likely to use safety net facilities.[[49]](#endnote-49)

* ***How will access to care vary in states that expand Medicaid vs. states that do not?***

A state that does not expand Medicaid could see a significantly greater percentage of clients (both citizens and immigrants) utilizing safety-net clinics. In states that do not expand Medicaid, citizens below the FPL will not be eligible for federal subsidies under an insurance exchange. Lawfully present immigrants with less than five years of residency, however, will be eligible for those tax credits and subsidies for private insurance under an exchange. The law intended for citizens below the FPL to be enrolled in Medicaid, thus not requiring the need for insurance through an exchange. The Supreme Court’s ruling in June 2012, however, effectively made Medicaid expansion a state option.[[50]](#endnote-50) Due to the effect of the Supreme Court ruling, some states that had previously opposed Medicaid expansion are now reconsidering their decision.[[51]](#endnote-51) As of March 2013, 25 states are either leaning against Medicaid expansion or undecided.[[52]](#endnote-52)

* ***How will the ACA affect immigrants participating in their states’ AIDS Drug Assistance Program (ADAP)?***

For immigrants living with HIV/AIDS, participation in ADAPs will continue to be available regardless of immigration status.[[53]](#endnote-53) Both undocumented immigrants and lawfully present immigrants who are eligible for Medicaid and/or private insurance under the ACA can continue to apply for ADAP.

* ***How can health departments help achieve increased health care access for immigrant populations under ACA?***

In implementing ACA, CMS has developed resources to increase awareness among those newly eligible for health benefits; for example, “Patient Navigators” are entities that will receive grants from exchanges to provide outreach and education on qualified health plans.[[54]](#endnote-54) Health departments and their community-based partners should consider whether it would be appropriate to apply for funding as a navigator. Apart from the Navigator program, health departments could implement their own educational programs for existing clients who are newly eligible for benefits.

**Resources on ACA Provisions Affecting Immigrants**

* [National Immigration Law Center (NILC)](http://nilc.org/) is a non-profit organization whose mission is to defend and advance the rights of low-income immigrants and their families. [NILC’s Health page](http://nilc.org/health.html) contains several informational resources on various provisions of the ACA.
* [The Kaiser Family Foundation](http://www.kff.org/) is a non-profit, private operating foundation focusing on the major health care issues facing the U.S. [The Kaiser Commission on Medicaid and the Uninsured page on Immigrants and Health Care Coverage](http://www.kff.org/uninsured/immigranthealth.cfm) contains several issue briefs on ACA implementation.

**NASTAD Resources on Health Reform**

* [NASTAD Health Reform Website](http://www.nastad.org/care_and_treatment/resources.aspx?category=health%20reform) houses NASTAD’s presentations, issue briefs, fact sheets, and other resources on health reform.
* [NASTAD Blog](http://blog.nastad.org/tag/health-reform/) provides timely updates and breaking news with regard to federal and state health reform implementation.
1. *See, e.g.,* Patient Protection and Affordable Care Act of 2010 § 1101(d)(1), 42 U.S.C. § 18001 (2010) (hereinafter Affordable Care Act) (stating that an eligible individual for Pre-Existing Condition Insurance Plans is a “citizen or national of the United States or is lawfully present in the United States”). [↑](#endnote-ref-1)
2. *See, e.g., id.* at § 1401(a) (describing rules for premium tax credit eligibility for families in which some members are “not lawfully present”). [↑](#endnote-ref-2)
3. *See* Alison Siskin, Cong. Research Serv., R41714, Treatment of Noncitizens Under the Patient Protection and Affordable Care Act 1-2 (2011). [↑](#endnote-ref-3)
4. *Key Facts on Health Coverage for Low-Income Immigrants Today and Under the Affordable Care Act*, Kaiser Family Found., 2 (Mar. 4, 2013), <http://www.kff.org/uninsured/upload/8279-02.pdf> (hereinafter Kaiser Family Foundation). [↑](#endnote-ref-4)
5. Pew Hispanic Center, A Nation of Immigrants: A Portrait of the 40 Million, Including 11 Million Undocumented (2013), *available at* <http://www.pewhispanic.org/files/2013/01/statistical_portrait_final_jan_29.pdf>. [↑](#endnote-ref-5)
6. *State Estimates of Low-Income Uninsured Not Eligible for the ACA Medicaid Expansion*, Robert Wood Johnson Found., 2 (Mar. 14, 2013), <http://www.rwjf.org/content/dam/farm/reports/issue_briefs/2013/rwjf404825> (hereinafter Robert Wood Johnson Foundation) (“Low income” refers to individuals between 0 and 138% of the Federal Poverty Line). [↑](#endnote-ref-6)
7. *The Affordable Care Act: Coverage Implications and Issues for Immigrant Families*, Department of Health and Human Services (HHS) Assistant Secretary for Planning and Evaluation (ASPE), 3 (Apr. 2012), <http://aspe.hhs.gov/hsp/11/ImmigrantAccess/Coverage/ib.shtml>. [↑](#endnote-ref-7)
8. Kaiser Family Foundation, *supra* note ii, at 4. [↑](#endnote-ref-8)
9. *Id.*; *see also* U.S. Census, Income, Poverty, and Health Insurance Coverage in the United States: 2011 21 (2012), *available at* <http://www.census.gov/prod/2012pubs/p60-243.pdf>. [↑](#endnote-ref-9)
10. Robert Wood Johnson Foundation, *supra* note iii, at 2. [↑](#endnote-ref-10)
11. Kaiser Family Foundation, *supra* note ii, at 5. [↑](#endnote-ref-11)
12. Ctrs. for Disease Control and Prevention, Basic Statistics, <http://www.cdc.gov/hiv/topics/surveillance/basic.htm#hivest> (last visited Apr. 12, 2013). [↑](#endnote-ref-12)
13. Ctrs. for Disease Control and Prevention, HIV Among Latinos, <http://www.cdc.gov/hiv/latinos/index.htm> (last visited Apr. 12, 2013). [↑](#endnote-ref-13)
14. Ctrs. for Disease Control and Prevention, HIV Surveillance Report (2011), Table 8, <http://www.cdc.gov/hiv/surveillance/resources/reports/2011report/index.htm>. [↑](#endnote-ref-14)
15. Dept. of Health and Human Serv., Combating the Silent Epidemic of Viral Hepatitis: Action Plan for the Prevention, Care & Treatment of Viral Hepatitis 1-3 (2011), *available at* <http://www.hhs.gov/ash/initiatives/hepatitis/actionplan_viralhepatitis2011.pdf> (referencing unpublished data from the Centers for Disease Control and Prevention). [↑](#endnote-ref-15)
16. Affordable Care Act, *supra* n. 1,§ 2001(a). The Act actually states the Medicaid eligibility threshold as 133 percent of the Federal Poverty Line, but 5 percent of income will be disregarded when calculating Modified Adjusted Gross Income (MAGI) for purposes of the law. *See Explaining Health Reform: The New Rules for Determining Income Under Medicaid in 2014*, Kaiser Family Found., 1 (Jun. 2, 2011), <http://www.kff.org/healthreform/upload/8194.pdf>. [↑](#endnote-ref-16)
17. Bernadette Fernandez and Annie L. Mach, Cong. Res. Serv. R42663, Health Insurance Exchanges Under the Patient Protection and Affordable Care Act (ACA) 17 (2013). [↑](#endnote-ref-17)
18. Ankita Rao, *As Refugees Settle In, Health Care Becomes a Hurdle*, Kaiser Health News, Apr. 17, 2013, *available at* <http://www.kaiserhealthnews.org/Stories/2013/April/17/Refugee-health-care.aspx>. [↑](#endnote-ref-18)
19. Siskin, *supra* n. 3, at 3. [↑](#endnote-ref-19)
20. Nat’l Fed’n of Indep. Bus. v. Sebelius, 132 S.Ct. 2566, 2607 (2012). [↑](#endnote-ref-20)
21. *Eligibility*, Medicaid.gov, <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Eligibility/Eligibility.html> (last visited Apr. 12, 2013). [↑](#endnote-ref-21)
22. Affordable Care Act, *supra* n. 1,at § 1301(a). [↑](#endnote-ref-22)
23. I.R.C. § 36B(c)(1)(A) (2011). [↑](#endnote-ref-23)
24. Affordable Care Act, *supra* n. 1,at§ 1402(c)(1). [↑](#endnote-ref-24)
25. I.R.C. § 36B(c)(1)(A) (2011). [↑](#endnote-ref-25)
26. I.R.C. § 36B(c)(1)(B) (2011). [↑](#endnote-ref-26)
27. Affordable Care Act, *supra* n. 1,at§ 1412(d). [↑](#endnote-ref-27)
28. Affordable Care Act, *supra* n. 1,at§ 1101(d). [↑](#endnote-ref-28)
29. *State High-Risk Pools: An Overview*, Kaiser Family Found., 2 (Jan. 2010), <http://www.kff.org/uninsured/upload/8041.pdf>. [↑](#endnote-ref-29)
30. Affordable Care Act, *supra* n. 1, at § 5601(a). [↑](#endnote-ref-30)
31. Affordable Care Act, *supra* n. 1, at § 2551(a). [↑](#endnote-ref-31)
32. Affordable Care Act, *supra* n. 1, at § 1411(a)(1). *See also Immigrants and the Affordable Care Act*, Nat’l Immigration Law Ctr. (March 2013), *available at* <http://nilc.org/immigrantshcr.html> (clarifying that verification requirements are in place for Medicaid and the Children’s Health Insurance Program along with the exchanges). [↑](#endnote-ref-32)
33. Affordable Care Act, *supra* n. 1, at § 1411(b)(1). [↑](#endnote-ref-33)
34. Affordable Care Act, *supra* n. 1, at § 4201(a). [↑](#endnote-ref-34)
35. Affordable Care Act, *supra* n. 1, at § 1001. [↑](#endnote-ref-35)
36. Sarah Kliff, *Immigration Reform Could Add 7 Million People to Obamacare*, Wash. Post, Jan. 29, 2013, *available at* <http://www.washingtonpost.com/blogs/wonkblog/wp/2013/01/29/immigration-reform-could-add-7-million-people-to-obamacare/>. [↑](#endnote-ref-36)
37. Border Security, Economic Opportunity, and Immigration Modernization Act of 2013, S. \_\_\_\_, 113th Cong. § 2101(a). [↑](#endnote-ref-37)
38. Border Security, Economic Opportunity, and Immigration Modernization Act of 2013, S. \_\_\_\_, 113th Cong. § 2101(a). [↑](#endnote-ref-38)
39. Memorandum from Janet Napolitano, Secretary of Homeland Security, to David V. Aguilar, Acting Commissioner, U.S. Customs and Border Protection, et al. (Jun. 15, 2012), *available at* <http://www.dhs.gov/xlibrary/assets/s1-exercising-prosecutorial-discretion-individuals-who-came-to-us-as-children.pdf>. The U.S. Citizenship and Immigration Services agency lists guidelines that individuals must meet in order to qualify for DACA at <http://www.uscis.gov/USCIS/Humanitarian/Deferred%20Action%20for%20Childhood%20Arrivals/daca-consider.pdf>. [↑](#endnote-ref-39)
40. *Frequently Asked Questions: Exclusion of People Granted “Deferred Action for Childhood Arrivals” from Affordable Health Care*, Nat’l Immigration Law Ctr. (Nov. 26, 2012), <http://www.nilc.org/acadacafaq.html>. [↑](#endnote-ref-40)
41. Letter from Cindy Mann, Director of Center for Medicaid and CHIP Services, Centers for Medicare & Medicaid Services, to state health officials and state Medicaid directors (Aug. 28, 2012), *available at* <http://www.medicaid.gov/Federal-Policy-Guidance/downloads/SHO-12-002.pdf>. [↑](#endnote-ref-41)
42. Pre-Existing Condition Insurance Plan Program, 77 Fed. Reg. 52,614 (Aug. 30, 2012) (to be codified at 42 C.F.R. pt. 152), *available at* <http://www.gpo.gov/fdsys/pkg/FR-2012-08-30/pdf/2012-21519.pdf>. [↑](#endnote-ref-42)
43. Patient Protection and Affordable Care Act: Establishment of Exchanges and Qualified Health Plans; Proposed Rule, 76 Fed. Reg. 41,868 (codified at 42 C.F.R. pts. 155 and 156). These proposed rules, which were finalized on May 29, 2012, reference 42 C.F.R. 152 (the Pre-Existing Condition Insurance Plan Program rules, *see* note xv *supra*) for definition of “lawfully present;” thereby confirming that DACA-eligible individuals, who are excluded from PCIP participation, are also excluded from exchange participation. [↑](#endnote-ref-43)
44. Medical Examination of Aliens – Removal of Human Immunodeficiency Virus (HIV) Infection from Definition of Communicable Disease of Public Health Significance, 74 Fed. Reg. 56, 547 (codified at 42 C.F.R. pt. 34). [↑](#endnote-ref-44)
45. Fear of risk of deportation is a common reason that mixed families cite for their reluctance to sign up eligible family members for health care coverage. *See Connecting Eligible Immigrant Families to Health Coverage and Care: Key Lessons from Outreach and Enrollment Workers*, Kaiser Commissioner on Medicaid and the Uninsured 7 (Oct. 3, 2011), *available at* <http://www.kff.org/medicaid/upload/Connecting-Eligible-Immigrant-Families-to-Health-Coverage-and-Care-Key-Lessons-from-Outreach-and-Enrollment-Workers-full-report-pdf.pdf>. [↑](#endnote-ref-45)
46. The California Immigrant Policy Center and National Immigration Law Center have advocated for beta-testing the online portals before the exchanges and Medicaid expansion are fully operational in 2014, in order to assuage concerns about the verification system among mixed-status families. *See, e.g., Making the Affordable Care Act Work for Immigrants in California*, Calif. Immigration Policy Ctr. (Spring 2012), *available at* <http://www.caimmigrant.org/>. [↑](#endnote-ref-46)
47. I.R.C. § 36B (2011). [↑](#endnote-ref-47)
48. *Frequently Asked Questions: Exclusion of People Granted “Deferred Action for Childhood Arrivals” from Affordable Health Care*, National Immigration Law Center (Nov. 26, 2012), <http://www.nilc.org/acadacafaq.html>. [↑](#endnote-ref-48)
49. Kaiser Family Foundation, *supra* note ii, at 7. [↑](#endnote-ref-49)
50. Nat’l Fed’n of Indep. Bus. v. Sebelius, 132 S.Ct. 2566, 2607 (2012). [↑](#endnote-ref-50)
51. Ricardo Alonso-Zaldivar, *Immigration Fallout from Saying No to Obamacare*, Associated Press, Jan. 23, 2013, *available at* <http://news.yahoo.com/immigration-fallout-saying-no-obamacare-194737397--politics.html> (noting that Arizona reluctantly decided to expand Medicaid, citing the quirk in the law as a major rationale). [↑](#endnote-ref-51)
52. *Status of ACA Medicaid Expansion After Supreme Court Ruling,* Ctr. for Budget and Policy Priorities (Mar. 13, 2012), *available at* <http://www.cbpp.org/files/status-of-the-ACA-medicaid-expansion-after-supreme-court-ruling.pdf>. [↑](#endnote-ref-52)
53. *HIV and Undocumented Immigrants: Your Legal Rights*, AIDS Legal Council of Chicago 10 (March 2013), *available at* <http://www.aidslegal.com/Publications/Undocumented_Immigrants_English.pdf>. [↑](#endnote-ref-53)
54. Patient Protection and Affordable Care Act; Exchange Functions: Standards for Navigators and Non-Navigator Assistance Personnel, 78 Fed. Reg. 20,581 (Apr. 5, 2013) (to be codified at 42 C.F.R. pt. 155), *available at* <http://www.gpo.gov/fdsys/pkg/FR-2013-04-05/pdf/2013-07951.pdf>. [↑](#endnote-ref-54)