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ISSUE BRIEF

Medicaid Access and Participation

A Data Profile of Eligible and Ineligible Immigrant Adults

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Executive Summary

Need for Medicaid, the largest public health insurance program for the non-elderly, low-income population in the United States, surged following the onset of the COVID-19 pandemic as millions of U.S. workers lost jobs, incomes, and employer-provided coverage. Between February 2020 and January 2021, almost 10 million working-age adults and children signed up for Medicaid and the companion Children's Health Insurance Program (CHIP). Immigrants are disproportionately low income, uninsured, and employed in sectors that suffered heavy job losses during the pandemic. Yet, federal law prohibits many of them from participating in Medicaid due to their immigration status.

To support understanding of the size and characteristics of this population, this issue brief describes the health coverage of foreign-born, non-elderly adults (ages 19 to 64). Using a unique methodology that assigns immigration status to noncitizens in the U.S. Census Bureau's American Community Survey (ACS) and models household size and income according to Medicaid rules, the brief lays out the number of immigrant adults who have incomes below the varying thresholds set by states and what shares of income-eligible foreign-born adults are excluded from participating in Medicaid due to their immigration status. The brief also presents estimated participation rates for immigrant adults eligible for the program and provides an overview of the characteristics of those who are excluded.

This analysis finds that 9.5 million non-elderly foreign-born adults had incomes that met state eligibility thresholds, but 45 percent of them (4.3 million adults) did not qualify for Medicaid due to immigration-status restrictions.

Based on 2019 ACS data, this analysis finds that 9.5 million non-elderly foreign-born adults had incomes that met state eligibility thresholds, but 45 percent of them (4.3 million adults) did not qualify for Medicaid due to immigration-status restrictions. Under the 1996 *Personal Responsibility and Work Opportunity Reconciliation Act* (PRWORA), naturalized U.S. citizens, lawful permanent residents (LPRs, also known as green-card holders) with at least five years in that status, immigrants admitted under certain specific, mostly humanitarian classifications such as refugees and asylees, and other specified groups are eligible for federally funded Medicaid; other noncitizens generally are not. Among income-eligible immigrants not qualifying for Medicaid due to their status in 2019, 75 percent (3.25 million) were unauthorized

immigrants, 13 percent (536,000) were LPRs with fewer than five years of permanent residency, and 12 percent (523,000) were nonimmigrants such as international students and temporary workers.

State Medicaid rules and the demographics of immigrant populations have a strong influence on who can participate in the program. The Medicaid income threshold for adults ranges, depending on eligibility pathway, from 0 percent to 221 percent of the federal poverty level (FPL), with 38 states and the District of Columbia expanding their thresholds as allowed under the *Affordable Care Act* (ACA), and 12 states setting much lower ones by not expanding them under the ACA. Considering all low-income, non-elderly foreign-born adults (those with incomes at or below 200 percent of the FPL) in 2019, the share not qualified for Medicaid based on income in the 12 non-expansion states was 78 percent—more than twice as high as in the 38 expansion states and Washington, DC (31 percent).

The states with the highest shares of income-eligible foreign-born adults meeting Medicaid's immigration-status requirements were Vermont (71 percent), Maine (69 percent), Minnesota (65 percent), Michigan (63 percent), and Florida (63 percent). In these states, naturalized citizens, LPRs with more than five years in that status, and other groups of immigrants who are federally eligible for Medicaid make up larger shares of the immigrant population; Florida, for example, has many immigrants in eligible humanitarian categories such as refugees, asylees, and Cuban-Haitian entrants. By contrast, the states with the lowest shares qualifying under Medicaid's immigration-status rules were Kansas (38 percent), Mississippi (39 percent), North Carolina (43 percent), Alabama (43 percent), and Utah (43 percent)—states with relatively high proportions of unauthorized immigrants and relatively low proportions of LPRs and naturalized citizens among their income-eligible non-elderly immigrant adult populations.

Five states plus the District of Columbia fund health coverage similar to Medicaid for substantial groups of immigrants excluded from the federal program due to their status. Washington, DC, has the most comprehensive program, covering essentially 100 percent of non-elderly adults regardless of their immigration status, while California covers unauthorized immigrants ages 19 to 26 and, as soon as May 2022, will cover unauthorized adults over age 50, in addition to almost all lawfully present noncitizens. Massachusetts, Minnesota, New York, and Pennsylvania cover most lawfully present noncitizens but not unauthorized immigrant adults. The state-funded programs reviewed in this analysis boosted eligibility by 18 to 48 percentage points among income-eligible immigrant adults in 2019, and about 1 million immigrants—11 percent of those excluded from the federal program—live in these states. Due to recent expansions of state programs, particularly in California, the proportion potentially covered by them is even greater today than in 2019.

This analysis also points to noteworthy racial/ethnic patterns in eligibility for Medicaid, with federally excluded income-eligible immigrant adults more likely to be Latino or Asian than U.S.-born adults with incomes below the state thresholds. Of the three major immigration-status groups restricted from eligibility, unauthorized immigrants are predominantly Latino, while Asians comprise relatively high shares of recent LPRs and nonimmigrants compared to the overall low-income U.S. adult population.

Foreign-born adults who meet income criteria but are ineligible for Medicaid due to their immigration status are also more likely than U.S.-born income-eligible adults to be parents and workers. In 2019, 42 percent of ineligible immigrant adults were parents, compared with 22 percent of similarly situated U.S.-born adults. In addition, 43 percent of ineligible immigrants were employed versus 36 percent of U.S.-born adults. These patterns were driven by unauthorized immigrant adults, who were far more likely than immigrants overall or U.S.-born adults

to be parents and/or employed. The high share of parents among ineligible immigrants means that many of their children are exposed to economic risks should a parent become sick and face extended time off work and/or major medical bills. Despite their high employment rate, many immigrants who are ineligible for Medicaid due to status—particularly those who are unauthorized—also lack employer coverage, making them dependent on income from work to cover medical bills.

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Looking at the nationwide population of adults ages 19 to 64 who were income eligible for Medicaid in their states in 2019 and did not have another form of insurance, the Medicaid participation rate for foreign-born adults meeting federal immigration requirements was lower than that for the U.S. born: 66 percent versus 76 percent. Complex immigrant eligibility rules and fears of participating in government programs may depress participation for eligible immigrants compared to the native born.

State-to-state variation in immigrant-eligibility rules and income-eligibility thresholds also appear to have a profound impact on state patterns of Medicaid participation, as those states with the most generous rules also exhibited the highest immigrant participation. Participation rates among eligible immigrant adults without another form of insurance varied from highs of 97 percent in Vermont, 90 percent in Massachusetts, 81 percent in Rhode Island, and 80 percent in Minnesota, New York, and the District of Columbia to lows of 25 percent in Alabama, 26 percent in Arkansas and Oklahoma, and 27 percent in South Carolina and Mississippi. The states with the highest rates were Medicaid expansion states that also had relatively high income thresholds and participation rates among all income-eligible adults. The states with the lowest participation rates among immigrant adults were all non-expansion states with very low income thresholds.

The public-health and massive unemployment crises triggered by the COVID-19 pandemic have underscored deep-rooted racial and ethnic health disparities across the country. Immigrants, especially Latinos, are over-represented in essential occupations that, simultaneously, have been critical to sustaining U.S. communities during the pandemic and that frequently lack employer health coverage. Because of their immigration status, many are also excluded from Medicaid eligibility. Broadening eligibility to include lawfully present foreign-born adults, as was generally the case before PRWORA was passed in 1996 and as was recommended by the bipartisan U.S. Commission on Civil Rights in 2002, could help reduce health disparities, promote a more inclusive and better funded health-care system, and shore up the U.S. economy during difficult times. The *Health Equity and Access under the Law (HEAL) for Immigrant Families Act*, introduced in Congress in May 2021, has received significant legislative support and proposes expanding access. According to this analysis, it would extend eligibility to an estimated 1.1 million non-elderly immigrant adults who are lawfully present in the United States but do not have a status that qualifies them under current law.

1 Introduction

The COVID-19 pandemic hit U.S. communities with twin crises of public health and employment. Mandatory stay-at-home orders put in place to curb the spread of the virus and to protect lives contributed to a slowdown of economic activity and millions of jobs lost. Due to unemployment and declining

incomes, close to 10 million people signed up for Medicaid, the United States' largest public health insurance program for the non-elderly, low-income population, and the companion Children's Health Insurance Program (CHIP) between February 2020 and January 2021, bringing the total number of participants to a historic high of 80 million.[1] This sudden and sharp increase in participation in federally funded health insurance is a reminder that such programs serve as a critical safety net for millions of families in America.

Low-wage frontline workers have been particularly affected by the pandemic as their jobs usually require contact with the public, exposing them to health risks, while often failing to provide health coverage.[2] Immigrants, women, and people of color are disproportionately represented in these occupations, and they are generally more likely to have low incomes and lack health insurance.[3] Immigrant women in particular had the highest unemployment rate throughout the pandemic, up until July 2021.[4] In 2019, prior to the pandemic, foreign-born adults ages 19 to 64 were more than twice as likely to be uninsured (35 percent) as U.S.-born adults in that age range (14 percent).[5] Unaffordability and ineligibility—including requirements linked to immigration status—are often cited as reasons for lacking insurance.[6]

Until 1996, with limited exceptions, noncitizens lawfully residing in the United States generally were eligible for Medicaid and other means-tested public benefits under the same terms as U.S. citizens. That changed when Congress enacted the *Personal Responsibility and Work Opportunity Reconciliation Act* (PRWORA) in 1996.[7] PRWORA introduced multiple restrictions to noncitizens' eligibility for a broad range of public benefits. For federally funded Medicaid, PRWORA made certain noncitizens totally ineligible and made most lawful permanent residents (LPRs, also known as green-card holders) and certain other immigrants ineligible for their first five years in that status, while providing exceptions to these bars for refugees, asylees, and immigrants with other, mostly humanitarian statuses (see Table 1 for details). Additionally, states were allowed to extend eligibility to federally ineligible noncitizens by using state funding without a federal match.

This issue brief focuses on eligibility for and participation in Medicaid by foreign-born adults ages 19 to 64. It presents estimates of the number of these adults who have incomes low enough to qualify for Medicaid, and among them, how many are federally eligible and federally ineligible for the program due to their immigration status under the categories set out in PRWORA. The brief also describes participation rates among these federally eligible and federally ineligible populations. To better understand the characteristics of the ineligible population, this analysis disaggregates results by parental status, gender, race/ethnicity, and employment status for three federally ineligible groups: LPRs with less than five years of U.S. residence, nonimmigrants such as international students and temporary workers, and unauthorized immigrants.

Immigrant adults ages 65 and older are not included in this analysis because eligibility rules for the elderly are different than for non-elderly adults. Moreover, for older adults, other considerations commonly apply such as their dual eligibility with Medicare and alternative income calculations to determine eligibility through pathways such as Supplemental Security Income (SSI) and Aged, Blind, or Disabled (ABD).[8] Nonetheless, other studies suggest that this population deserves special attention: even when eligible, the Medicaid participation rate of elderly immigrants is considerably lower than their participation in Medicare,[9] is generally lower than for elderly U.S.-born individuals,[10] and has declined over time.[11] A subsequent publication by the Migration Policy Institute (MPI) will examine eligibility for and participation in CHIP and Medicaid by children of immigrants (ages 0 to 18).

TABLE 1
Noncitizen Eligibility for Medicaid under Federal Law

Eligible without a Five-Year Bar	Eligible but Subject to Five-Year Bar	Ineligible Immigrants
▶ Refugees (and holders of derivative visas*) ▶ Asylees (and holders of derivative visas*) ▶ Cuban/Haitian entrants ▶ Amerasians ▶ Victims of trafficking ▶ Iraqi or Afghan Special Immigrant Visa (SIV) holders ▶ Withholding of removal grantees ▶ Veterans; active duty military members; and their spouses, unremarried widows, or children ▶ Children receiving federal Foster Care ▶ Pregnant people and children and youth under age 21 who are lawfully residing in the United States, if state elected this option ▶ Supplemental Security Income (SSI) recipients ▶ Citizens of Palau, Micronesia, and the Mar shall Islands who lawfully reside in the United States under the Compacts of Free Association (COFA)**	▶ Lawful permanent residents (LPRs, also known as green-card holders) ▶ Parolees, if paroled into the United States for one year or longer ▶ Certain domestic violence survivors, including *Violence Against Women Act* (VAWA) self-petitioners	▶ Unauthorized immigrants ▶ Deferred Action for Childhood Arrivals (DACA) beneficiaries and others granted deferred action ▶ Nonimmigrants, including U-visa holders*** ▶ Temporary Protected Status (TPS) beneficiaries ▶ Asylum seekers ▶ Certain employment-based visa and student visa holders

* The spouse or minor unmarried children (younger than age 21) of the beneficiary of an immigrant petition may apply for derivative status.
** Entrants under COFA are permitted to study, reside, and work in the United States indefinitely, but are not lawful permanent residents.
*** The U nonimmigrant status (U visa) is for victims of certain crimes who are helpful to law enforcement or government officials in the investigation or prosecution of criminal activity.
Sources: United States Citizenship and Immigration Services (USCIS), "Derivative Refugee/Asylum Status for Your Children," updated July 9, 2020; Karina Fortuny and Ajay Chaudry, "Overview of Immigrants' Eligibility for SNAP, TANF, Medicaid, and CHIP" (issue brief, U.S. Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation, Washington, DC, March 2012), 9–10; Emily McCabe and Leslye E. Orloff, "Comparison Chart of VAWA and U Visa Immigrant Relief" (chart, National Immigrant Women's Advocacy Project, American University, Washington College of Law, June 20, 2014); USCIS, "Victims of Criminal Activity: U Nonimmigrant Status," updated June 12, 2018; Claire R. Thomas and Ernie Collette, "Barring Survivors of Domestic Violence from Food Security: The Unintended Consequences of 1996 Welfare and Immigration Reform," *Drexel Law Review* 9 (2017): 379–380.

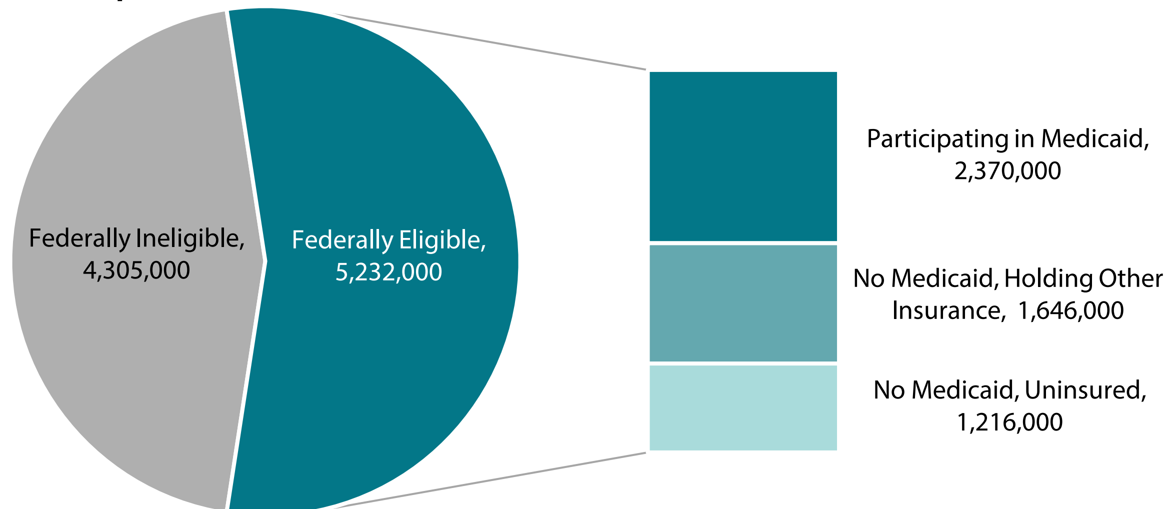
2 Impact of Federal Restrictions: Estimates of Income-Eligible Immigrant Adults Federally Eligible and Ineligible for Medicaid

Medicaid is a public insurance program for low-income families and individuals that was created in 1965 under the Johnson administration and expanded subsequently, including under the *Affordable Care Act* (ACA) of 2010.[12] Medicaid is jointly financed by the federal government and states. The federal government requires states to cover certain mandatory populations and services, but states can choose to extend eligibility and coverage within the federal statute's basic framework.[13] The *Social Security Act* additionally authorizes waivers under certain circumstances that allow states to cover additional populations or otherwise modify their Medicaid programs.[14] Consequently, Medicaid eligibility varies greatly across states.

Based on analysis of ACS data, an estimated 9.5 million non-institutionalized foreign-born adults ages 19 to 64 had incomes that met state income-eligibility thresholds for Medicaid in 2019 (see Figure 1). Due to immigration-status-based restrictions imposed by federal law, 4.3 million of these income-eligible immigrant adults (45 percent of the total) did not have access to federally funded Medicaid. Of the remaining 5.2 million who held an immigration status that made them eligible, 2.4 million were Medicaid participants, 1.7 million were nonparticipants but had other insurance, and 1.2 million were uninsured.

FIGURE 1

Estimated Medicaid Income-Eligible Foreign-Born Adults (ages 19–64), by Federal Immigration-Status Eligibility and Participation, United States, 2019



Note: Numbers may not add up to the total due to rounding. Other insurance includes public coverage other than Medicaid, such as Medicare or the Department of Veterans Affairs insurance, and private insurance. Based on U.S. Census Bureau definitions, private insurance can include employer-sponsored coverage, plans purchased by individuals from private insurance companies, TRICARE, or other military health-care coverage.
Source: These 2019 data result from MPI analysis of data from the 2015–19 American Community Survey (ACS), pooled, and the 2008 Survey of Income and Program Participation (SIPP), weighted to 2019 unauthorized immigrant population estimates provided by Jennifer Van Hook at The Pennsylvania State University.

BOX 1
Determination of Income Eligibility and Federal Eligibility

Individuals generally qualify for Medicaid by meeting the requirements of an eligibility pathway. Each pathway specifies the category of individuals covered and the financial requirements applicable to that group, as well as residency and immigration requirements and certain state-based criteria. For most pathways, financial eligibility is determined on the basis of monthly modified adjusted gross income (MAGI) and its percentage of the federal poverty level (FPL). Certain populations are exempt from MAGI-counting rules, and eligibility is determined following rules that most closely match the related social program for that group. For example, Supplemental Security Income (SSI) rules are followed for participants in that program. Depending on the state, receipt of SSI may automatically qualify an individual for Medicaid without the need for further application. States also have the option to establish a "medically needy program" for individuals with significant health costs but income too high to qualify for Medicaid.

In this analysis, the authors used data from the 2015–19 American Community Survey (ACS), pooled, and the 2008 Survey of Income and Program Participation (SIPP) to impute immigration status and identify the federally eligible and ineligible immigrants under PRWORA (see Table 2 and its notes for definitions). The ACS has the advantage of large, nationally representative samples sizes that allow for detailed analyses of small populations, such as the state immigrant populations broken down by status studied in this brief. A shortcoming of the ACS is that income variables are not well-suited for computing MAGI: the survey's reference period is yearly, not monthly, and it does not collect details on sources of income. For this analysis, the researchers employed an alternative income measure— adjusted gross income (AGI)—which draws on a shorter list of income sources available in the ACS and is calculated annually. Because the determination of income sources is limited and monthly income volatility cannot be captured, AGI calculations may result in an underestimate of the number of people income eligible for Medicaid.

To determine the non-institutionalized, income-eligible population, this analysis used ACS households and information on family relationships to construct family units resembling the health insurance units that form the basis for Medicaid eligibility determination. The authors then computed a family income to poverty ratio using AGI and poverty guidelines by the U.S. Department of Health and Human Services, and accounting for state-specific income limits and other eligibility pathways effective between 2015 and 2019. Pathways to Medicaid by parental status and SSI recipient/disability status were modeled, but pregnancy status was not, due to data limitations.

Sources: Common eligibility groups include low-income parents, pregnant people, and young children. See Centers for Medicare and Medicaid Services (CMS), "Medicaid, Children's Health Insurance Program, & Basic Health Program Eligibility Levels," updated October 2020; Alison Mitchell et al., *Medicaid: An Overview* (Washington, DC: Congressional Research Service, 2021. "Medically needy" persons can become eligible by spending down the amount of income above the state's needy income standard. See CMS, "Medicaid—Eligibility," accessed July 27, 2021. The methodology used in this analysis allows for the identification of the most important immigration statuses described in Table 1: lawful permanent residents (with and without five years of U.S. residence), nonimmigrants, unauthorized immigrants, refugees, asylees, and Cuban/Haitian entrants. Other smaller categories cannot be captured. For a discussion on MAGI, AGI, and the implications of using different national datasets, see U.S. Department of Health and Human Services (HHS), Office of the Assistant Secretary for Planning and Evaluation, "Data Sources for Modified Adjusted Gross Income (MAGI) Conversions" (issue brief, HHS Office of the Assistant Secretary for Planning and Evaluation, Washington, DC, February 3, 2013). For an explanation of health insurance units, see Rachel Garfield, Kendal Orgera, and Anthony Damico, "The Coverage Gap: Uninsured Poor Adults in States that Do Not Expand Medicaid" (issue brief, Kaiser Family Foundation, San Francisco, January 21, 2021), Technical Appendix A: Household Construction. For examples of AGI calculations using the ACS, see Brookings Institution, "Economic and Demographic Profiles of the EITC-Eligible Population: A Guide to Understanding and Using the Data," updated 2016. For information on the maximum income threshold by pathways to access Medicaid, see Kaiser Family Foundation, "State Health Facts—Medicaid & CHIP," accessed September 16, 2021.

State-by-State Estimates

There are large variations between states in terms of how many foreign-born adult residents each has and the share of those adults who are eligible for federally funded Medicaid. Notable trends as of 2019 include:

- One-third of all foreign-born adults between the ages of 19 and 64 with incomes low enough to qualify for Medicaid (3.1 million people) lived in California (see Table 2). New York and New Jersey ranked a distant second and third, with approximately 1.2 million and 468,000 Medicaid income-eligible immigrant adults, respectively.

- Looking at the proportion of each state's income-eligible foreign-born adults who were federally eligible for Medicaid, the highest-ranking states were Vermont (71 percent), Maine (69 percent), Minnesota (65 percent), Michigan (63 percent), and Florida (63 percent). When compared with other states, these states have proportionately more naturalized citizens, LPRs with more than five years in that status, and other groups of immigrants who are federally eligible for Medicaid. Florida is a top state for refugees, asylees, and Cuban-Haitian entrants.[15] Vermont and Maine have relatively small numbers of refugees, but refugees represent 9 percent and 6 percent, respectively, of the income-eligible foreign-born adult population in these states, significantly more than the national average of 1 percent. Moreover, these two states, along with Minnesota and Michigan, have among the highest shares of income-eligible immigrants who are naturalized U.S. citizens. At the national level, 30 percent of income-eligible immigrant adults ages 19 to 64 were naturalized citizens; this share was 49 percent in Maine, 43 percent in Vermont, 42 percent in Minnesota, 41 percent in Michigan, and 37 percent in Florida.

- At the other extreme, states with the lowest shares of income-eligible immigrants who were federally eligible in 2019 were Kansas (38 percent), Mississippi (39 percent), North Carolina (43 percent), Alabama (43 percent), and Utah (43 percent). In these states, unauthorized immigrants and nonimmigrants—groups that are ineligible for Medicaid—make up relatively large shares of the income-eligible immigrant population.

TABLE 2

Estimated Medicaid Income-Eligible Adults (ages 19 to 64), by Nativity and Federal Eligibility, 50 States and District of Columbia, 2019

	Income-Eligible U.S.-Born Adults	**Income-Eligible Foreign-Born Adults**					
		Total	Federally Eligible for Medicaid		Federally Ineligible for Medicaid		Federally Ineligible, Eligible for State Replacement Option
	Number	*Number*	*Number*	*Share of Total*	*Number*	*Share of Total*	*Number*
Alabama	417,000	16,000	7,000	43%	9,000	57%	
Alaska	105,000	12,000	8,000	62%	5,000	38%	
Arizona	1,042,000	322,000	173,000	54%	150,000	46%	
Arkansas	578,000	55,000	24,000	44%	30,000	56%	

TABLE 2 (cont.)

Estimated Medicaid Income-Eligible Adults (ages 19 to 64), by Nativity and Federal Eligibility, 50 States and District of Columbia, 2019

	Income-Eligible U.S.-Born Adults	Income-Eligible Foreign-Born Adults					
		Total	Federally Eligible for Medicaid		Federally Ineligible for Medicaid		Federally Ineligible, Eligible for State Replacement Option
	Number	*Number*	*Number*	*Share of Total*	*Number*	*Share of Total*	*Number*
California	5,006,000	3,116,000	1,710,000	55%	1,407,000	45%	654,000
Colorado	693,000	145,000	74,000	51%	71,000	49%	
Connecticut	482,000	129,000	67,000	52%	62,000	48%	
Delaware	145,000	25,000	13,000	51%	13,000	49%	
District of Columbia	138,000	31,000	16,000	52%	15,000	48%	15,000
Florida	1,241,000	411,000	259,000	63%	151,000	37%	
Georgia	734,000	96,000	47,000	49%	49,000	51%	
Hawaii	182,000	63,000	35,000	55%	28,000	45%	
Idaho	78,000	7,000	4,000	48%	4,000	52%	
Illinois	1,803,000	463,000	253,000	55%	210,000	45%	
Indiana	931,000	102,000	45,000	44%	57,000	56%	
Iowa	421,000	52,000	26,000	51%	26,000	49%	
Kansas	129,000	18,000	7,000	38%	11,000	62%	
Kentucky	876,000	57,000	28,000	48%	29,000	52%	
Louisiana	741,000	48,000	21,000	45%	27,000	55%	
Maine	119,000	6,000	4,000	69%	2,000	31%	
Maryland	745,000	202,000	102,000	51%	100,000	49%	
Massachusetts	859,000	266,000	141,000	53%	124,000	47%	71,000
Michigan	1,726,000	177,000	111,000	63%	66,000	37%	
Minnesota	624,000	129,000	84,000	65%	45,000	35%	21,000
Mississippi	300,000	7,000	3,000	39%	4,000	61%	
Missouri	357,000	23,000	10,000	44%	13,000	56%	
Montana	156,000	5,000	3,000	52%	2,000	48%	
Nebraska	72,000	18,000	9,000	48%	9,000	52%	
Nevada	401,000	169,000	91,000	54%	78,000	46%	
New Hampshire	167,000	14,000	8,000	55%	6,000	45%	
New Jersey	996,000	468,000	260,000	56%	208,000	44%	
New Mexico	401,000	78,000	42,000	55%	35,000	45%	
New York	2,640,000	1,201,000	735,000	61%	467,000	39%	218,000
North Carolina	695,000	83,000	35,000	43%	47,000	57%	

TABLE 2 (cont.)

Estimated Medicaid Income-Eligible Adults (ages 19 to 64), by Nativity and Federal Eligibility, 50 States and District of Columbia, 2019

	Income-Eligible U.S.-Born Adults	Income-Eligible Foreign-Born Adults					
		Total	Federally Eligible for Medicaid		Federally Ineligible for Medicaid		Federally Ineligible, Eligible for State Replacement Option
	Number	*Number*	*Number*	*Share of Total*	*Number*	*Share of Total*	*Number*
North Dakota	90,000	8,000	4,000	51%	4,000	49%	
Ohio	1,933,000	138,000	74,000	54%	63,000	46%	
Oklahoma	275,000	23,000	10,000	44%	13,000	56%	
Oregon	626,000	119,000	61,000	52%	58,000	48%	
Pennsylvania	1,986,000	228,000	132,000	58%	96,000	42%	47,000
Rhode Island	161,000	39,000	24,000	62%	15,000	38%	
South Carolina	404,000	30,000	13,000	44%	17,000	56%	
South Dakota	41,000	3,000	-	-	-	-	
Tennessee	600,000	61,000	27,000	44%	34,000	56%	
Texas	1,425,000	430,000	200,000	46%	230,000	54%	
Utah	121,000	23,000	10,000	43%	13,000	57%	
Vermont	100,000	6,000	4,000	71%	2,000	29%	
Virginia	559,000	101,000	51,000	51%	50,000	49%	
Washington	904,000	249,000	130,000	52%	119,000	48%	
West Virginia	395,000	9,000	4,000	49%	5,000	51%	
Wisconsin	633,000	54,000	29,000	54%	25,000	46%	
Wyoming	26,000	2,000	-	-	-	-	
U.S. Total	**36,281,000**	**9,537,000**	**5,231,000**	**55%**	**4,305,000**	**45%**	**1,025,000**

Notes: Numbers may not add up to the total due to rounding. Categories marked "-" have a sample size too small to generate statistically meaningful results. This analysis uses a simplified set of immigration statuses to estimate the federally eligible foreign-born population: naturalized U.S. citizens, lawful permanent residents (LPRs) with more than five years in that status, refugees, asylees, Haitian/Cuban entrants, and Iraqi and Afghan Special Immigrant Visa (SIV) holders. Other specific statuses shown in Table 1 could not be captured due to data limitations. The federally ineligible population includes: LPRs with fewer than five years in that status; holders of temporary nonimmigrant visas such as international students, H-1B high-skilled temporary workers, and H-2A agricultural workers; Temporary Protected Status (TPS) beneficiaries; asylum seekers with work authorization; and Deferred Action for Childhood Arrivals (DACA) beneficiaries. LPRs who had held that status for at least five years could not be modeled, so those with at least five years of total U.S. residence were used as a proxy. Determination of the federal poverty level (FPL) is based on the authors' computation of family to poverty ratio to account for adjusted gross income and poverty guidelines set by HHS.

Sources: These 2019 data result from MPI analysis of data from the 2015–19 ACS, pooled, and the 2008 SIPP, weighted to 2019 unauthorized immigrant population estimates provided by Van Hook. Estimates of the lawfully present immigrant population are based a combination of administrative records: USCIS, "Count of Active DACA Recipients by Month of Current DACA Expiration as of Dec. 31, 2020," updated January 2021; Jill Wilson, *Temporary Protected Status: Overview and Current Issues* (Washington, DC: Congressional Research Service, 2020); USCIS, "Form I-1765 Application for Employment Authorization: All Receipts, Approvals, Denials Grouped by Eligibility Category and Filing Type," fiscal years 2019 and 2020; data on employment authorization documents approved by state, with approval dates through June 18, 2018, obtained by the authors from USCIS through a *Freedom of Information Act* (FOIA) request.

3 Impact of State Medicaid Income Thresholds and State-Funded Replacement Programs

State discretion over setting maximum income limits to access Medicaid has important consequences and has led to uneven access to health care across the United States. Monthly family income limits for adults range from 17 percent to 221 percent of the federal poverty level (FPL) for parents of children ages 17 and under, and from 0 percent to 215 percent for nonparents.[16] States that implemented the ACA Medicaid expansion have maximum income limits that are no lower than 138 percent of the FPL for both parents and nonparents (see Box 2). However, eligibility limits in states that have not adopted the Medicaid expansion are much lower, and in most of these states, adults without dependent children are not eligible for Medicaid, regardless of income, unless they qualify through a disability pathway.

Non-expansion states typically have very low income limits and reduced pathways for adults to access Medicaid. Similar shares of the United States' immigrant population live in Texas and Florida as in New York (11 percent and 10 percent versus 10 percent, respectively); yet, because Texas and Florida have not expanded Medicaid, few adult immigrants in these two states meet the income eligibility criteria.[17] The 2019 maximum income limit for parents was 17 percent of the FPL in Texas and 32 percent of the FPL in Florida, but 138 percent of the FPL in New York.[18] As a result, while 1.3 million foreign-born non-elderly adults were income eligible in New York, fewer than 426,000 and 407,000 were eligible in Texas and Florida, respectively (see Table 2).

BOX 2
***Affordable Care Act* and Medicaid Expansions**

Through the ACA, states have had the option since January 1, 2014, to extend Medicaid coverage to certain non-elderly adults with incomes up to 138 percent of the FPL. The ACA created significant incentives for states to opt into this expansion, including an increase in federal funding to cover 100 percent of the expansion (less administrative costs) for the first three years, phasing down to 90 percent thereafter. In 2014, 25 states implemented the Medicaid expansion, and 14 more joined in later years. From July 2013 to July 2020, there was an increase in enrollment of 15.9 million adults in states that adopted the expansion. The *American Rescue Plan Act of 2021* provides an additional temporary fiscal incentive for states that have not yet taken up the expansion to do so, but to date 12 states continue to elect to not expand Medicaid.

Sources: Congressional Research Service, "Overview of the ACA Medicaid Expansion" (fact sheet, June 9, 2021); Robin Rudowitz, Bradley Corallo, and Rachel Garfield, "New Incentive for States to Adopt the ACA Medicaid Expansion" (issue brief, Kaiser Family Foundation, San Francisco, March 17, 2021); Laura Snyder, Samantha Artiga, Robin Rudowitz, and Jessica Stephens, "An Overview of New CMS Data on the Number of Adults Enrolled in the ACA Medicaid Expansion" (issue brief, Kaiser Family Foundation, San Francisco, February 2, 2015); Kaiser Family Foundation, "Status of State Action on the Medicaid Expansion Decision," updated February 22, 2021. On Medicaid enrollment since the ACA, see Medicaid and CHIP Payment Access Commission, "Medicaid Enrollment Changes Following the ACA," accessed February 21, 2020. For Medicaid and the American Rescue Plan, see MaryBeth Musumeci. "Key Questions about the New Increase in Federal Medicaid Matching Funds for COVID-19" (issue brief, Kaiser Family Foundation, San Francisco, May 4, 2020).

TABLE 3

Estimated Shares of Low-Income Immigrant Adults (ages 19–64) Ineligible for Federally Funded Medicaid due to State Income Limits, by ACA Medicaid Expansion Status, 2019

	Number of Foreign-Born Adults (ages 19–64) with Income < 200% of FPL	Share Not Eligible for Medicaid Based on State Income Limits Only
Non-ACA Expansion States	5,486,000	78%
ACA Expansion States & District of Columbia	11,985,000	31%
United States	17,471,000	45%

Notes: Twelve states have not adopted the Medicaid expansion through the Affordable Care Act: Alabama, Florida, Georgia, Kansas, Mississippi, North Carolina, South Carolina, South Dakota, Tennessee, Texas, Wisconsin, and Wyoming. Low-income adults are those with family incomes below twice the federal poverty level (FPL). Determination of FPL is based on the authors' computation of family to poverty ratio to account for adjusted gross income and poverty guidelines set by HHS.
Source: These 2019 data result from MPI analysis of data from the 2015–19 ACS, pooled, and the 2008 SIPP, weighted to 2019 unauthorized immigrant population estimates provided by Van Hook.

Using a standard definition of "low income" as income below twice the federal poverty level, there were an estimated 17.5 million low-income immigrant adults ages 19 to 64 living in the United States in 2019. Of those adults, 5.5 million, or 31 percent, lived in non-expansion states (see Table 3). At the national level, 45 percent of low-income foreign-born adults were not eligible for Medicaid in their state of residence because their income exceeded limits set by the state. The share of low-income foreign-born adults who were ineligible due to low income thresholds or income eligibility restrictions was 78 percent in non-expansion states, more than twice the rate of 31 percent in expansion states and the District of Columbia.

Finally, low-income non-elderly adults in non-expansion states face yet another hurdle to accessing affordable, comprehensive health insurance: the Medicaid coverage gap. The ACA provides tax credits/subsidies for coverage in the health insurance marketplaces to individuals with incomes between 100 percent and 400 percent of the FPL. In expansion states, Medicaid covers individuals with incomes up to 138 percent of the FPL and individuals with incomes between 138 percent and 400 percent of the FPL are eligible for tax credits/subsidies under the ACA, meaning that access to subsidized health insurance is possible for all individuals with incomes below 400 percent of FPL.[19] In non-expansion states, Medicaid eligibility is typically limited to those with incomes less than 100 percent of the FPL, and while tax credits for health coverage apply to those with incomes between 100 percent and 400 percent of the FPL, people with incomes below 100 percent of the FPL are generally ineligible for both Medicaid and tax credits/subsidies. An estimated 2.2 million uninsured adults fall into this coverage gap, with more than half being people of color.[20]

State-Funded Replacement Programs

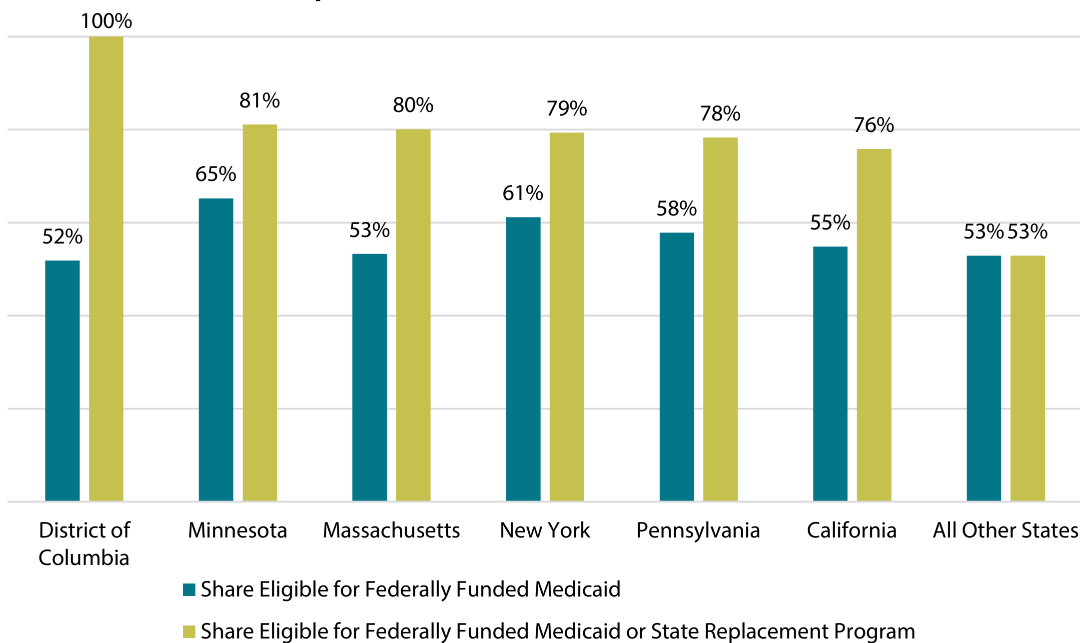
While federal law prohibits the use of federal Medicaid matching funds to cover certain noncitizens, states may choose to use their own funds to provide health-care coverage to noncitizens ineligible for federally funded Medicaid.[21] In California, the District of Columbia, Massachusetts, Minnesota, New York, and Pennsylvania, specific programs extend coverage to some foreign-born adults who are lawfully present in the country.[22] In 2019, slightly more than 1 million adults, or about 11 percent of foreign-born, income-eligible adults, were federally ineligible but resided in states that offer a state-funded program equivalent to Medicaid (see Table 2).[23] The present analysis did not consider state programs that offer very limited health-care services and/or reduced premium reimbursements.

Although states can use their own funds to cover federally ineligible individuals, they can only serve unauthorized immigrants through affirmative state legislation. The District of Columbia extends state-funded Medicaid to all income-eligible unauthorized immigrant adults, making it the most inclusive program and effectively eliminating all legal barriers to coverage for noncitizen adults.[24] California, which has the largest number of federally ineligible immigrants, offers state-funded coverage for income-eligible unauthorized immigrants between the ages of 19 and 26, and as early as May 2022, it plans to cover those over age 50.[25] Illinois, which currently covers people age 65 and older regardless of immigration status, has committed to covering unauthorized immigrant adults ages 55 to 64 by May 2022.[26] Because the data analyzed in this brief are for 2019, the estimates below do not account for the newly or soon to be eligible adults in California or Illinois.

Extending state-funded health coverage to federally ineligible noncitizens substantially reduces the population of uninsured adults in those states. For example, in 2019, state-funded replacement programs increased the income-eligible foreign-born adult population eligible for federally funded Medicaid or a state replacement program from an estimated 55 percent to 76 percent in California, and from 52 percent to 100 percent in the District of Columbia (see Figure 2).

FIGURE 2

Estimated Shares of Income-Eligible Immigrant Adults (ages 19–64) Eligible for Federal Medicaid or State-Funded Medicaid Equivalent, Selected States, 2019



Notes: For federally ineligible foreign-born adults who are eligible for state-replacement programs, this analysis combined administrative records and Census data to construct a group of "lawfully present" immigrants that includes LPRs with fewer than five years of permanent residence; holders of nonimmigrant visas (international students, H1B-holders, etc.); TPS beneficiaries; asylum seekers with work authorization; and DACA beneficiaries. Estimates for the District of Columbia include unauthorized immigrant adults ages 19 to 64. California estimates only include coverage available for unauthorized immigrant adults ages 19 to 26. Based on 2019 data, MPI estimates that California's new law extending coverage to immigrants ages 50 and older would bring the share of the state's income-eligible foreign-born adults who are eligible for federal or state replacement to 80 percent, up from 76 percent.
Sources: These 2019 data result from MPI analysis of data from the 2015–19 ACS, pooled, and the 2008 SIPP, weighted to 2019 unauthorized immigrant population estimates provided by Van Hook. Estimates of the lawfully present immigrant population are based on a combination of administrative records: USCIS, "Count of Active DACA Recipients"; Wilson, *Temporary Protected Status*; USCIS, "Form I-1765 Application for Employment Authorization," fiscal years 2019 and 2020; data on employment authorization documents approved by state, with approval dates through June 18, 2018, obtained by the authors from USCIS through a FOIA request.

4 Medicaid Participation among Foreign- and U.S.-Born Income-Eligible Adults

Among adults without another form of insurance, the Medicaid participation rate for income-eligible immigrant adults meeting federal immigration requirements is substantially lower than the participation rate for income-eligible U.S.-born adults. In 2019, the Medicaid participation rate of income-eligible U.S.-born adults ages 19 to 64 was an estimated 76 percent, compared to 66 percent for income-eligible immigrants who met the immigration-status requirements set by PRWORA (see Table 4). These estimates fall within a range similar to those published in other recent studies.[27]

Consistent with most research on Medicaid participation rates, these estimates exclude income-eligible adults who have another form of insurance, though it should be acknowledged that neither quality, cost, nor consistency of these alternatives can be evaluated. As such, other insurance held by income-eligible adults may not be equivalent to Medicaid, resulting in some being underinsured. Moreover, the surge in Medicaid enrollment during the pandemic demonstrates that private insurance coverage may be lost as jobs are lost in times of crisis.

Nationwide, in 2019, about one-quarter (24 percent) of income-eligible U.S.-born adults were not enrolled in Medicaid. There were large variations in participation rates by state:

- The highest participation rates for U.S.-born income-eligible adults occurred in Massachusetts (91 percent), Vermont (90 percent), the District of Columbia (89 percent), Rhode Island (88 percent), and Connecticut (87 percent).
- The lowest participation rates for U.S.-born adults were in Texas (52 percent), Oklahoma (52 percent), South Dakota (56 percent), Georgia (57 percent), and North Dakota (61 percent).

Overall, the participation rate for federally eligible immigrant adults was 10 percentage points lower than for U.S.-born adults, again with considerable variation among states:

- In general, the states with the highest participation rates for immigrants also had high participation rates for U.S.-born adults, as described above. The highest rates for immigrants were in Vermont (97 percent), Massachusetts (90 percent), Rhode Island (81 percent), Minnesota (80 percent), the District of Columbia (80 percent), and New York (80 percent).
- All but one of the states with replacement programs for federally ineligible immigrant adults also had participation rates above the U.S. average of 66 percent: California, District of Columbia, Massachusetts, Minnesota, and New York. Pennsylvania's rate was at the U.S. average.
- The lowest participation rates for Medicaid among federally eligible immigrants were in Alabama (25 percent), Arkansas (26 percent), Oklahoma (26 percent), South Carolina (27 percent), and Mississippi (27 percent). As of 2019, these states had not implemented the ACA's Medicaid expansion and also had among the country's lowest participation rates for adults overall.[28]

States that expanded Medicaid to low-income adults under the ACA generally also had higher participation rates than states that did not expand it. Some evidence suggests that in non-expansion states, noncitizens have been more reluctant to participate in Medicaid and that Medicaid coverage gains in families where members have different immigration

statuses were much lower than gains in families where all members have the same status.[29] States that expanded Medicaid also invested more into awareness campaigns, outreach, and program visibility, which contributed to increasing their participation rates.[30]

TABLE 4

Estimated Medicaid Participation Rates among Income-Eligible Adults (ages 19–64), by Nativity and Federal Eligibility, 50 States and the District of Columbia, 2019

	U.S. Born	Immigrants Federally Eligible	Immigrants Federally Ineligible
Alabama (No ACA expansion)	63%	25%	15%
Alaska	61%	65%	-
Arizona	72%	61%	33%
Arkansas	74%	26%	7%
California	80%	73%	48%
Colorado	78%	55%	20%
Connecticut	87%	65%	20%
Delaware	81%	63%	30%
District of Columbia	89%	80%	53%
Florida (No ACA expansion)	62%	47%	11%
Georgia (No ACA expansion)	57%	28%	7%
Hawaii	81%	74%	45%
Idaho	68%	57%	-
Illinois	78%	53%	19%
Indiana	69%	46%	20%
Iowa	82%	63%	25%
Kansas (No ACA expansion)	66%	36%	12%
Kentucky	85%	58%	17%
Louisiana	74%	51%	12%
Maine	80%	79%	-
Maryland	81%	59%	18%
Massachusetts	91%	90%	73%
Michigan	81%	75%	40%
Minnesota	82%	80%	32%
Mississippi (No ACA expansion)	61%	27%	4%
Missouri	66%	47%	7%
Montana	69%	-	-
Nebraska	65%	46%	17%
Nevada	70%	46%	13%
New Hampshire	72%	60%	21%
New Jersey	77%	57%	17%
New Mexico	79%	61%	25%
New York	86%	80%	50%

TABLE 4 (cont.)

Estimated Medicaid Participation Rates among Income-Eligible Adults (ages 19–64), by Nativity and Federal Eligibility, 50 States and the District of Columbia, 2019

	U.S. Born	Immigrants Federally Eligible	Immigrants Federally Ineligible
North Carolina (No ACA expansion)	67%	33%	11%
North Dakota	61%	63%	-
Ohio	79%	68%	19%
Oklahoma	52%	26%	6%
Oregon	81%	66%	35%
Pennsylvania	79%	66%	26%
Rhode Island	88%	81%	44%
South Carolina (No ACA expansion)	65%	27%	7%
South Dakota (No ACA expansion)	56%	-	-
Tennessee (No ACA expansion)	70%	39%	8%
Texas (No ACA expansion)	52%	34%	14%
Utah	68%	32%	7%
Vermont	90%	97%	-
Virginia	64%	39%	8%
Washington	82%	65%	26%
West Virginia	83%	58%	-
Wisconsin (No ACA expansion)	80%	65%	19%
Wyoming (No ACA expansion)	66%	-	-
United States	**76%**	**66%**	**34%**

Notes: Categories marked "-" have a sample size too small to generate statistically meaningful results. Participation rates are computed by taking the ratio of Medicaid recipients to the income-eligible population in the respective groups: the numerator is the reported number of Medicaid participants who are income eligible, and the denominator is all income-eligible individuals minus those who have another insurance. See Table 1 for definitions of federally eligible and ineligible immigrants. Determination of FPL is based on the authors' computation of family to poverty ratio to account for adjusted gross income and poverty guidelines set by HHS.
Source: These 2019 data result from MPI analysis of data from the 2015–19 ACS, pooled, and the 2008 SIPP, weighted to 2019 unauthorized immigrant population estimates provided by Van Hook.

Medicaid Participation by Adults Who Are Ineligible for Federally Funded Medicaid due to Immigration Status

It is noteworthy that among noncitizen adults who had incomes below the Medicaid threshold but were ineligible due to their immigration status, 34 percent or 1.1 million individuals, reported participating in the program in 2019 (see Table 4). Several factors may explain this finding.

First, some lawfully present noncitizens and unauthorized immigrants are eligible for a state-replacement program; as discussed above, approximately 1 million federally ineligible immigrant adults reside states that offer such programs (see Table 2). In addition, others may fall under exceptions that cannot be captured by the data (see Table 1). For example, pregnancy status cannot be determined in the dataset, yet as of July 2021, 25 states had opted into the *Children's Health Insurance Program Reauthorization Act of 2009* (CHIPRA) option to cover lawfully present immigrants who are pregnant but would otherwise be ineligible due to their immigration status.[31] Some states also extend coverage to all pregnant immigrants, including those who are unauthorized, for

prenatal care, labor and delivery, and in some cases approximately two months of postpartum care through the CHIPRA option.[32]

Second, ACS respondents may inadvertently report participating in Medicaid when using Emergency Medicaid or state or locally funded health coverage programs that are not as comprehensive as Medicaid. Emergency Medicaid is available for immigrants who are ineligible for other coverage due to immigration status, but it is only meant for situations where the patient's health is in serious jeopardy. Emergency Medicaid cannot be used for preventive care, nor does it cover long-term care for chronic conditions.[33] For example, it could cover costs related to a heart attack but not management of heart disease, and birth but not prenatal care.

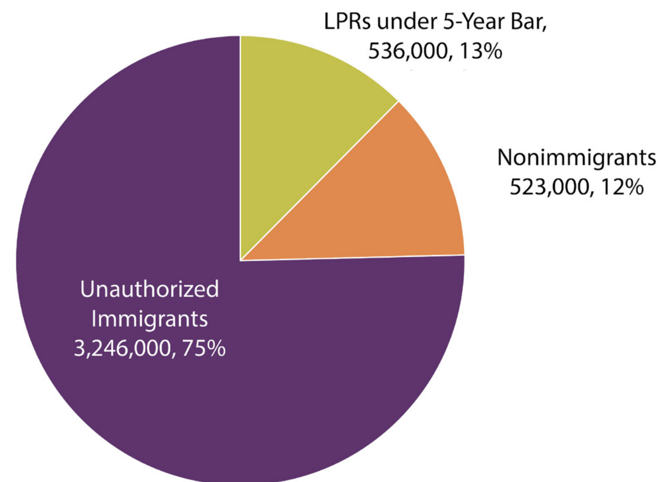
Individuals who benefit from the exceptions to immigration-status bars on Medicaid, or who participate in Emergency Medicaid or state or local programs, likely appear in the federally ineligible group, and their number and participation rate cannot accurately be estimated given the limitations of the data. This suggests that Medicaid participation by the federally ineligible may be overestimated, but since participants in that category represent about 11 percent of all income-eligible foreign-born adults, this bias is unlikely to affect the general conclusions of this brief.

5 Characteristics of Foreign-Born Adults Who Are Federally Ineligible for Medicaid due to Immigration-Status Restrictions

Although they met the income threshold for Medicaid, almost 4.3 million immigrants, or 45 percent of all foreign-born income-eligible adults in 2019, could not access the program due to their immigration status. Approximately 75 percent were unauthorized immigrants, 13 percent were lawful permanent residents with fewer than five years in that status (LPRs under the five-year bar), and 12 percent were nonimmigrants residing temporarily in the United States, such as international students and temporary workers (see Figure 3).[34] This section explores the characteristics of people who are income eligible for Medicaid but are excluded due to their immigration status, including the percentage who are parents, their race and ethnicity, and their employment rates.

FIGURE 3

Estimated Medicaid Income-Eligible Foreign-Born Adults (ages 19–64) Who Are Federally Ineligible due to Immigration Status, United States, 2019



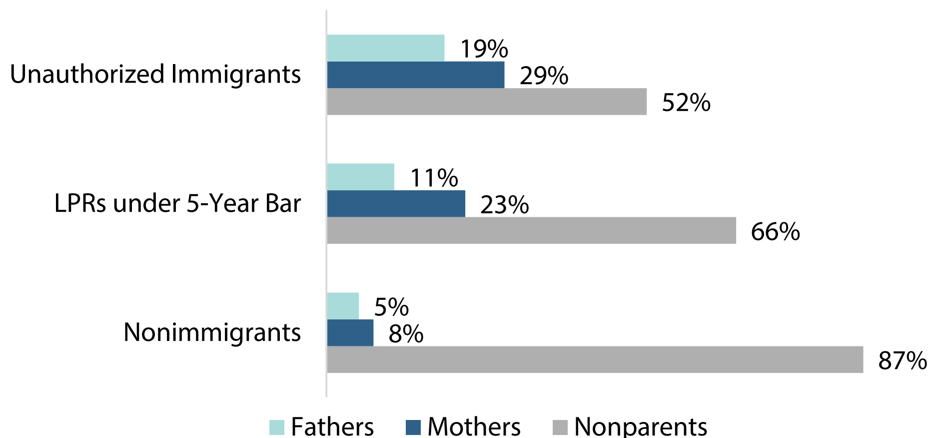
Note: See Table 1 for definitions of federally ineligible immigrant groups.
Source: These 2019 data result from MPI analysis of data from the 2015–19 ACS, pooled, and the 2008 SIPP, weighted to 2019 unauthorized immigrant population estimates provided by Van Hook.

A. Parents Federally Excluded due to Immigration Status

Parents were overrepresented among income-eligible adults excluded from Medicaid due to immigration status, but mothers were more likely to be excluded from coverage than fathers. According to this analysis, an estimated 42 percent of federally ineligible immigrant adults were parents living with

FIGURE 4

Parental Status of Medicaid Income-Eligible Foreign-Born Adults (ages 19–64) Who Are Federally Ineligible due to Immigration Status, United States, 2019



Notes: See Table 1 for definitions of federally ineligible immigrant groups. In this analysis, mothers and fathers are those adults who have a child living in their household who is between 0 and 17 years old. Nonparents do not have a child ages 0 to 17 living in their household.
Source: These 2019 data result from MPI analysis of data from the 2015–19 ACS, pooled, and the 2008 SIPP, weighted to 2019 unauthorized immigrant population estimates provided by Van Hook.

children under age 18: 26 percent were mothers, and 16 percent were fathers. By contrast, 22 percent of U.S.-born income-eligible adults were parents.

Unauthorized immigrants had the highest share of parents among federally excluded immigrant groups. Nearly one in two (48 percent) income-eligible unauthorized immigrant adults had a child under age 18, and unauthorized immigrant mothers alone represented 29 percent of all excluded unauthorized immigrant adults (see Figure 4). By contrast, parents represented 34 percent of LPRs subject to the five-year bar, and most ineligible nonimmigrants (87 percent) were not parents.

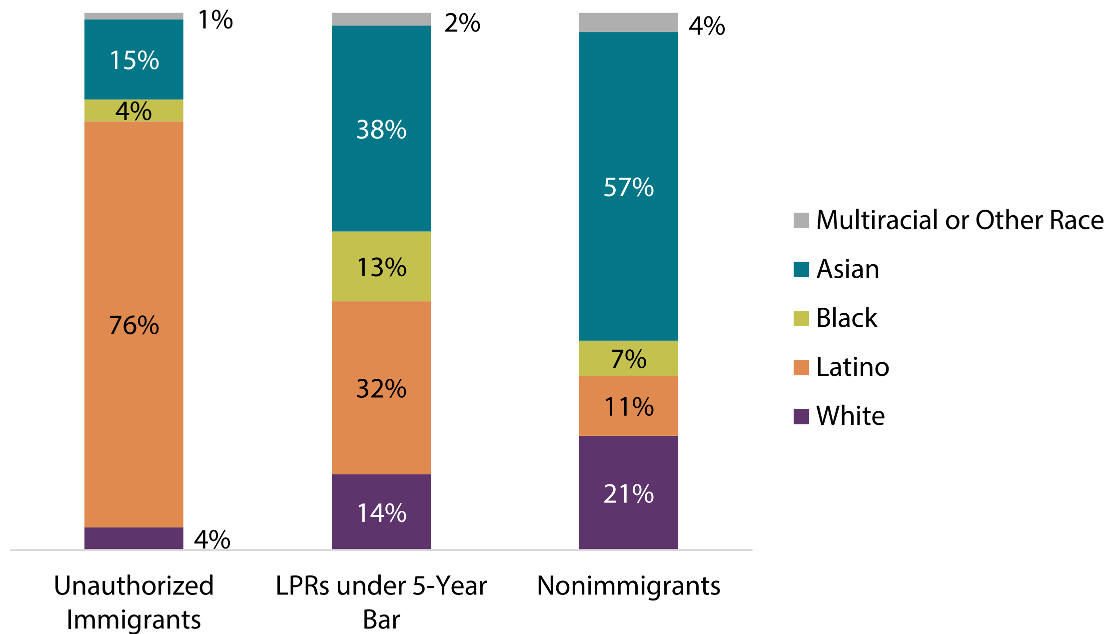
In 2019, more than 2.8 million children are estimated to have been living with income-eligible parents who could not access comprehensive, affordable health insurance due to their immigration status. These children may be missing out on the positive spillover effects of having parents with health insurance. For example, research has shown that children of Medicaid participants, particularly those under 5 years old,[35] are more likely to receive pediatric primary care.[36] While the children themselves may be insured through Medicaid or CHIP, living with a parent who is barred from Medicaid can make a household more vulnerable to hardship if parents lose jobs and employer coverage, as evidenced by the pandemic.[37]

B. Race and Ethnicity of Federally Excluded Immigrants

The majority of income-eligible immigrant adults ages 19 to 64 excluded from Medicaid due to federal income-status restrictions come from Mexico, China, Guatemala, El Salvador, and India. While Latinos already represent the largest racial/ethnic group in the U.S. immigrant population—in 2019, they were 44 percent of the total foreign-born population[38]—they are significantly overrepresented among federally ineligible immigrant adults. In 2019, Latinos comprised more than six in ten (62 percent) Medicaid income-eligible immigrant adults who were federally ineligible due to immigration status. By comparison, Latinos represented 15 percent of the U.S.-born income-eligible non-elderly adult population, ranking third after White (60 percent) and Black adults (18 percent).

FIGURE 5

Race and Ethnicity of Medicaid Income-Eligible Foreign-Born Adults (ages 19–64) Who Are Federally Ineligible due to Immigration Status, United States, 2019



Notes: See Table 1 for definitions of federally ineligible immigrant groups. All categories are exclusive, and all Latinos are included in that category regardless of their race. Native Americans are excluded due to small sample size.
Source: These 2019 data result from MPI analysis of data from the 2015–19 ACS, pooled, and the 2008 SIPP, weighted to 2019 unauthorized immigrant population estimates provided by Van Hook.

A closer look at immigration status shows that the overrepresentation of Latinos among federally excluded immigrants was limited to the unauthorized, of whom three-quarters were Latinos (see Figure 5). In contrast, Asian immigrants made up the largest shares of immigrants with other federally ineligible statuses, representing 38 percent of LPRs under the five-year bar and 57 percent of nonimmigrants.

The racial divide in health and financial outcomes has been vividly highlighted during the pandemic: Black and Latino households were particularly hard hit as they have experienced higher numbers of COVID-19 cases, deaths, and more financial distress than other racial/ethnic groups.[39] These findings show that as a result of federal policy, a disproportionate number of non-elderly immigrant adults from racial/ethnic minority groups—mainly low-income Latinos and Asians—faced the additional challenge of being barred from affordable and quality health care.

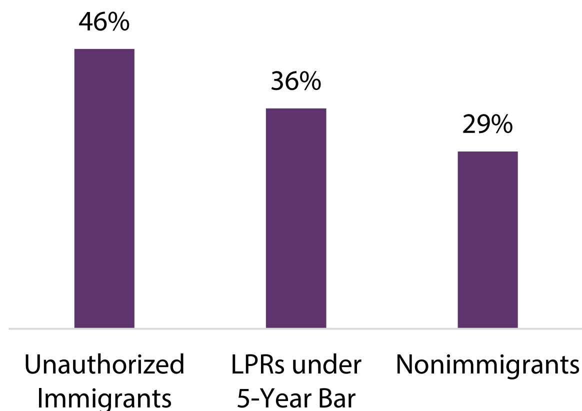
C. *Employment Rates of Federally Excluded Income-Eligible Adults*

In 2019, an estimated 43 percent of all income-eligible immigrant adults ages 19 to 64 who were ineligible for Medicaid due to their immigration status were employed, compared to 36 percent of income-eligible U.S.-born adults. Comparing the different groups of federally excluded income-eligible immigrant adults, unauthorized immigrants had the highest employment rate (46 percent)—substantially higher than for LPRs under the five-year bar (36 percent) and nonimmigrants (29 percent), as shown in Figure 6.

Thus, except for nonimmigrant visa holders, foreign-born adults ages 19 to 64 who are barred from accessing Medicaid due to federal immigration-status restrictions are just as likely or more likely to be in the labor force than U.S.-born adults in the same income range. Despite legal restrictions on hiring unauthorized immigrants, this group already has high labor force participation rates, but unauthorized immigrants may also find it necessary to work to gain employer coverage, if available through their job, or to earn additional income to cover health services when uninsured.

FIGURE 6

Employment Rates of Medicaid Income-Eligible Foreign-Born Adults (ages 19 to 64) Who Are Federally Ineligible due to Immigrant Status, 2019



Note: See Table 1 for definitions of federally ineligible immigrant groups.
Source: These 2019 data result from MPI analysis of data from the 2015–19 ACS, pooled, and the 2008 SIPP, weighted to 2019 unauthorized immigrant population estimates provided by Van Hook.

6 Conclusion

The twin crises of public health and massive unemployment triggered by the COVID-19 pandemic have underscored the health disparities that exist across the United States. While anyone may be vulnerable to the virus, the consequences for low-income people have been particularly severe. Low-income communities of color, both U.S. born and immigrants, have been disproportionally affected in terms of hospitalizations, deaths, and job losses. The sharp increase in Medicaid enrollment during this period is further evidence that when employment-related health coverage is lost, people may turn to this important safety-net program—with the notable exception of foreign-born adults barred from doing so because of their immigration status.

Since the 1996 enactment of the PRWORA, noncitizens have faced heightened barriers to accessing affordable and comprehensive health insurance. In 2019, a year before the pandemic began, approximately 4.3 million immigrants ages 19 to 64 had incomes low enough to qualify for Medicaid but were excluded solely based on their immigration status. Compared with U.S.-born adults in the same income range, federally ineligible immigrant adults were more likely to identify as Latino or Asian, to be a parent living with a child under age 18, and they were more likely to be employed. Uneven access to health care is linked to worse outcomes in prevention, detection, and treatment of illnesses.

The ramifications of the federal law go beyond the individual immigrants barred from Medicaid and have a potentially adverse impact on their families and the communities in which they live. In 2019, approximately 2.8 million children lived with an immigrant parent who was income eligible for Medicaid but could not participate due to immigration status. And yet immigrants, especially those belonging to a racial/ethnic minority, are over-represented in low-wage occupations that have been considered essential to sustaining U.S. communities during the pandemic—jobs that typically require direct contact with the public but often offer little to no health coverage.

The ramifications of the federal law go beyond the individual immigrants barred from Medicaid and have a potentially adverse impact on their families and the communities in which they live.

Federal ineligibility is not the only barrier to immigrant participation in Medicaid; state discretion over maximum income limits and which federally ineligible immigrant groups to cover also helps determine eligibility and access. Of the estimated 5.2 million immigrant adults who met both income and immigration-status requirements in 2019, 1.2 million were uninsured. Moreover, excluding those who have other health insurance, the Medicaid participation rate of federally eligible immigrant adults was 66 percent, or 10 percentage points lower than for income-eligible U.S.-born adults. A state-by-state analysis revealed significant differences in participation rates, and that these differences are correlated with state-set eligibility rules; the 12 states that have not expanded Medicaid through the *Affordable Care Act* have the lowest participation rates overall.

Some states have broadened eligibility for Medicaid-like programs in the face of federal restrictions on immigrants' eligibility. Five states plus the District of Columbia have implemented state-funded replacement programs that are equivalent to Medicaid and cover lawfully present immigrant adults. Some state-funded programs go further: in Washington, DC, all unauthorized immigrant adults are eligible for publicly funded health care, and California currently extends coverage to unauthorized immigrants ages 19 to 26 and plans to also cover those ages 50 and older as soon as May 2022.

Back in 2002, the U.S. Commission on Civil Rights, a bipartisan, independent commission, called for the reinstatement of full benefits to lawfully present immigrants to mitigate the immigration-status requirements the commission deemed discriminatory. The commission additionally recommended that Congress extend certain public assistance programs—such as health care, education, and food stamps—to unauthorized immigrants.[40] In May 2021, the *Health Equity and Access under the Law (HEAL) for Immigrant Families Act* was introduced in Congress. This bill contains a provision to extend Medicaid to lawfully present immigrants who meet all other eligibility requirements. Based on this analysis of Medicaid income eligibility, this would affect an estimated 1.1 million immigrant adults ages 19 to 64: at least 536,000 LPRs ineligible at present because they have been in the country for fewer than five years and 523,000 nonimmigrants. Broadening eligibility to include lawfully present foreign-born adults is a policy change that could reduce disparities in health care based on immigration status and promote a more inclusive health-care system.

Endnotes

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