Public Comments in SUPPORT of Maryland's Request to Amend 1332 State Innovation Waiver

U.S. Department of Health and Human Services and the Department of the Treasury ("the Departments")

September 13, 2024

Dear Secretary Becerra and Secretary Yellen,

I am pleased to offer public comments on behalf of the Congregation Action Network (CAN) in strong **support of Maryland's request to amend its 1332 State Innovation Waiver**. CAN is an interfaith network striving to create a community where everyone, no matter their immigration status, has the same access to rights and resources. We have supported efforts over numerous years to ensure everyone in Maryland, regardless of their immigration status, has access to healthcare.

Maryland's 2024 request to amend its 1332 State Innovation Waiver tackles key health disparities in the immigrant community by extending Affordable Care Act coverage to all eligible Marylanders, regardless of immigration status. The data is stark - immigrant Marylanders make up only 6% of the state's population but uninsured immigrant Marylanders account for more than 30% of the state's uninsured rate. Meeting all federal statutory guardrails, this waiver request is instrumental in tackling the disproportionately high uninsured rate among immigrant Marylanders.

Access to healthcare affects an individual's health, well-being, and life expectancy. It can prevent diseases and disabilities, detect and treat illnesses, increase the quality of life, reduce the likelihood of premature death, and increase life expectancy.[1] The Institute of Medicine estimates that 18,000 Americans died in one year because they were

[1] https://www.healthypeople.gov/2020/leading-health-indicators/2020-lhi-topics/Access-to-Health-Services

uninsured.[2] **This waiver will ensure that Marylanders have access to both comprehensive health coverage and comprehensive hands-on support through the health insurance enrollment process.** Currently, immigrant Marylanders cannot enroll and do not have any support to enroll in the state's health insurance marketplace.

In addition to tackling the uninsured rate, this waiver request will also tackle child poverty and child health outcomes in Maryland, especially within the large immigrant community in Maryland. Studies show that children of immigrants are more likely to lack health insurance than children of U.S.-born citizens.[3] With this new opportunity, immigrant parents will be able to compare coverage options and enroll in the same plans as their children leading to cost savings on premiums for families. Removing the immigration requirement will ensure that more people, regardless of their immigration status, get healthcare.

This waiver request aligns with the Centers for Medicare & Medicaid Services mission to provide all those served with the highest level of health and well-being, and to eliminate disparities in health care quality and access. CAN strongly urges an approval of this waiver request.

Rev. Julio Hernández

Executive Director, Congregation Action Network

[2] https://www.commonwealthfund.org/blog/2019/insurance-coverage-saves-lives
[3] https://www.ncbi.nlm.nih.gov/books/NBK224446/

JEWS UNITED FOR JUSTICE
THINK JEWISHLY. ACT LOCALLY.

Public Comments in SUPPORT of Maryland's Request to Amend 1332 State Innovation Waiver

U.S. Department of Health and Human Services and the Department of the Treasury ("the Departments")

September 13, 2024

Dear Secretary Becerra and Secretary Yellen,

I am pleased to offer public comments on behalf of Jews United for Justice (JUFJ) in strong support of Maryland's request to amend its 1332 State Innovation Waiver. JUFJ organizes more than 6,000 Jewish Marylanders and allies from across the state in support of social, racial, and economic justice campaigns. We are a proud partner of CASA and have supported this effort over numerous years to ensure everyone in Maryland, regardless of their immigration status, has access to healthcare.

Maryland's 2024 request to amend its 1332 State Innovation Waiver tackles key health disparities in the immigrant community by extending Affordable Care Act coverage to all eligible Marylanders, regardless of immigration status. The data is stark, immigrant Marylanders make up only 6% of the state's population but uninsured immigrant Marylanders account for more than 30% of the state's uninsured rate. Meeting all federal statutory guardrails, this waiver request is instrumental in tackling the disproportionately high uninsured rate among immigrant Marylanders.

Access to healthcare affects an individual's health, well-being, and life expectancy. It can prevent diseases and disabilities, detect and treat illnesses, increase the quality of life, reduce the likelihood of premature death, and increase life expectancy.[1] Black and Brown residents continue to become sicker, are hospitalized at higher rates, and die younger as they are forced to face life-or-death situations without healthcare coverage. The Institute of Medicine estimates that 18,000 Americans died in one year because they were uninsured.[2] **This waiver will ensure that Marylanders have access to**

[1] https://www.healthypeople.gov/2020/leading-health-indicators/2020-lhi-topics/Access-to-Health-Services
[2] https://www.commonwealthfund.org/blog/2019/insurance-coverage-saves-lives

both comprehensive health coverage and comprehensive hands-on support through the health insurance enrollment process. Currently, immigrant Marylanders cannot enroll and do not have any support to enroll in the state's health insurance marketplace.

Maryland does not provide health insurance plans through its state insurance marketplace to undocumented Marylanders.**This waiver will extend coverage to thousands of residents who currently lack coverage.** In addition to tackling the uninsured rate, this waiver request will also tackle child poverty and child health outcomes in Maryland. Studies show that children of immigrants are more likely to lack health insurance than children of U.S.-born citizens. Furthermore children of color, particularly, Black and Latino children, fare comparably worse than their White peers with similar backgrounds.[3] With this new opportunity, immigrant parents will be able to compare coverage options and enroll in the same plans as their children leading to cost savings on premiums for families. Removing the immigration requirement will ensure that more people, regardless of their immigration status, get healthcare.

This waiver request aligns with the Centers for Medicare & Medicaid Services mission to provide all those served with the highest level of health and well-being, and to eliminate disparities in health care quality and access. JUFJ strongly urges an approval of this waiver request.

Thank you for your consideration,

Jerry Kickenson (on behalf of Jews United for Justice)

[3] https://www.ncbi.nlm.nih.gov/books/NBK224446/

LICENSED CLINICAL PROFESSIONAL COUNSELORS OF MARYLAND

September 20, 2024

The Honorable Xavier Becerra, Secretary
U.S. Department of Health and Human Services
200 Independence Avenue, SW
Washington, D.C., 20201

The Honorable Janet Yellen, Secretary
U.S. Department of the Treasury
1500 Pennsylvania Avenue, NW
Washington, D.C., 20220

Re: Comments on Maryland Health Benefit Exchange 1332 Waiver Amendment Application

Dear Secretary Becerra and Secretary Yellen,

The Licensed Clinical Professional Counselors of Maryland (LCPCM) represents over 4,000 licensed professional counselors in Maryland. Our highest priority is increasing access to behavioral health care for all Marylanders. We are writing today because we want to express our support of the Maryland Health Benefit Exchange's (MHBE) 1332 waiver amendment application, which would allow people, who do not have legal residency status in Maryland, to purchase insurance on the Maryland Health Connection. This waiver would permit those individuals to take advantage of the Health Connection's navigators who would make the health insurance purchasing process understandable and easier.

If families can purchase coverage, they will be far more likely to access behavioral health services.[i] We cannot afford to deny people the opportunity to purchase health insurance. The cost of untreated mental illness is staggering because of the downstream health, educational, and social costs.[ii] This waiver amendment can only yield positive results. It requires no state investment yet will result in more people being able to obtain the coverage they need to ensure their families wellbeing. Additionally, these individuals will be able to benefit from MHBE's streamlined shopping experience that enables individuals to evaluate plans from all individual market insurers in a single location and conveniently compare plan costs, verify whether their providers and prescription medications are included in the plans, and utilize available tools to estimate overall healthcare expenses, thereby assisting them in selecting the most suitable plan for their requirements.

Thank you for the opportunity to submit these comments. LCPCM fully supports MHBE's 1332 waiver amendment as a critical and effective step to improve access and inevitably patient outcomes in the behavioral health field. If we can provide further information, please contact myself at hillarybethalexander@gmail.com or our public policy and governmental affairs consultant, Robyn Elliott, at relliott@policypartners.net.

Sincerely,
Hillary Alexander. LCPCM
President

[i] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6477535/
[ii] https://jamanetwork.com/journals/jama-health-forum/fullarticle/2810448

masbhc
MARYLAND ASSEMBLY ON
SCHOOL-BASED HEALTH CARE
education+health=success

September 20, 2024

The Honorable Xavier Becerra, Secretary
U.S. Department of Health and Human Services
200 Independence Avenue, SW
Washington, D.C., 20201

The Honorable Janet Yellen, Secretary
U.S. Department of the Treasury
1500 Pennsylvania Avenue, NW
Washington, D.C., 20220

Re: Comments on Maryland Health Benefit Exchange 1332 Waiver Amendment Application

Dear Secretary Becerra and Secretary Yellen,

The Maryland Assembly on School-Based Health Care (MASBHC) represents almost 90 school-based health centers in Maryland. Our highest priority is increasing access to primary, behavioral health, and dental care for children in communities with high rates of poverty. We are writing today in support of the Maryland Health Benefit Exchange's 1332 waiver amendment application, which would allow people regardless of their legal residency status to buy insurance through the Maryland Health Connection.

MASBHC supports the waiver application because it would expand access to health insurance for children with immigrant parents. Immigrants have high rates of employment, yet they are far more likely to be uninsured.[i] Children in immigrant families are twice as likely to be uninsured.[ii] Uninsured children are at high risk for not having a medical home.[iii]

Once implemented, Maryland's waiver application will reduce the number of children without insurance and increase access to health care services. Some immigrant families have sufficient resources to purchase their own insurance, but may not have the tools to navigate the individual insurance marketplace. They will be able to turn to the Maryland Health Connection which provides navigation support services, including in-person and call center support, for people who do not speak English fluently.

Thank you for consideration of our comments. If we can provide any further information, please contact Robyn Elliott at relliott@policypartners.net.

Sincerely,
Patryce A. Toye, MD. FACP, MBA
President, MASBHC

[i] https://www.kff.org/racial-equity-and-health-policy/fact-sheet/key-facts-on-health-coverage-of-immigrants/

[ii] Kemmick Pintor J, Call KT. State-Level Immigrant Prenatal Health Care Policy and Inequities in Health Insurance Among Children in Mixed-Status Families. Global Pediatric Health. 2019;6. doi:10.1177/2333794X19873535

[iii] Uninsured US kids do not reap benefits of medical homes, study finds. Natalie McGillThe Nation's Health April 2016, 46 (3) E12

Maryland Community Health System

September 20, 2024

The Honorable Xavier Becerra, Secretary
U.S. Department of Health and Human Services
200 Independence Avenue, SW
Washington, D.C., 20201

The Honorable Janet Yellen, Secretary
U.S. Department of the Treasury
1500 Pennsylvania Avenue, NW
Washington, D.C., 20220

Re: Comments on Maryland Health Benefit Exchange 1332 Waiver Amendment Application

Dear Secretary Becerra and Secretary Yellen,

The Maryland Community Health System (MCHS) strongly supports the Maryland Health Benefit Exchange's (MHBE) 1332 waiver amendment application, which would allow people, who do not have legal residency status in Maryland, to purchase insurance on the Maryland Health Connection. This waiver would permit those individuals to take advantage of the Health Connection's navigators who would make the health insurance purchasing process understandable and easier.

MCHS is a network of seven federally qualified health centers with 55 care delivery sites across the state of Maryland. Our mission is to ensure underserved communities have access to somatic, behavioral, and oral health care. Community health centers become federally qualified health centers with a special designation by the Health Services and Resources Administration under the Department of Health and Human Services. To qualify, federally qualified health centers must be located in health professional shortage areas and commit to never closing the door because a patient is uninsured or too low-income to pay for care. All federally qualified health centers provide services under a sliding fee scale. Most of our patients do pay for their health care services, although it may be a reduced rate for some.

Currently, there are thousands of Maryland residents who are working with an Individual Tax Identification Number (ITIN), who are earning money, paying Maryland and federal taxes, but are denied the benefits that their taxes are paying for, such as unemployment insurance, Social Security and access to affordable health care on the Exchange. During Maryland's legislative session, we heard from individuals that have the ability to pay once a waiver amendment is approved and they become eligible. If the waiver amendment is approved, the

acquiring of insurance will ultimately be a streamlined shopping experience that enables consumers to evaluate plans from all individual market insurers in a single location, will allow consumers to effortlessly compare plan costs, verify whether their providers and prescription medications are included in the plans, and utilize available tools to estimate overall healthcare expenses, thereby assisting them in selecting the most suitable plan for their requirements.

With this wavier, MCHS will be able to attempt to address its uncompensated care issue. Several factors contribute to the high levels of uncompensated care in FQHCs. One of the primary contributors is the high number of uninsured or underinsured individuals seeking care at these centers. A number of our uninsured patients are unable to obtain insurance coverage because of their legal residency status. Efforts like this, to increase access to care, is certainly a step in the right direction, but many people still find themselves without coverage due to economic or eligibility constraints.

In addition to the insurance gap, socioeconomic factors play a significant role in the accumulation of uncompensated care. Individuals from low-income communities, who are more likely to use MCHS services, often cannot afford the out-of-pocket costs associated with healthcare, even with a sliding fee scale, leading to higher rates of uncompensated care. Additionally, the requirement for FQHCs to provide care regardless of a patient's ability to pay, places a financial burden on these centers without offering a corresponding increase in funding to cover the costs of care provided.

Thank you for the opportunity to submit these comments. MCHS fully supports MHBE's 1332 waiver amendment as a critical and effective step to get more people insured. If we can provide further information, please contact myself at salborn@mchsmd.com or our public policy and governmental affairs consultant, Robyn Elliott, at relliott@policypartners.net.

Sincerely,
Salliann Alborn, CEO
Maryland Community Health System

Public Comments: Maryland 1332 Waiver Amendment Application
By Stephanie Klapper, Deputy Director, Maryland Health Care for All! Coalition
September 13, 2024

Thank you for this opportunity to submit public comments in support of the 1332 waiver amendment application to allow Maryland residents, who do not have current legal residency status, to purchase health insurance through Maryland Health Connection. We urge CMS to approve this waiver as soon as possible so that it may start benefitting our residents.

If approved by CMS, this waiver amendment will help more Marylanders receive navigational support from Maryland Health Connection to compare insurance plans, including easier-to-compare Value Plans not available off-Exchange. This is a step toward ending healthcare disparities for immigrant communities in Maryland. It will ensure access to primary care, resulting in higher early detection rates and better long-term management of chronic diseases and serious illnesses. It will decrease the amount of costly emergency room visits and mortality rates. Often uninsured Marylanders have to wait until their health issues bring them to the emergency room, which increases hospital wait times and also increases uncompensated care. According to our hospitals, the State is spending between $120—170M per year in uncompensated care for emergency department services for Marylanders who do not have insurance. Uncompensated care drives up health insurance premiums for everyone.

When Marylanders can access coverage, they can access preventive care, which allows them to stay healthier and have fewer visits to the emergency room. We recently released a report showing that past health care expansion in Maryland reduced uncompensated care by at least $460 million, making coverage more affordable for everyone else. This waiver amendment will help ensure more Marylanders can purchase coverage, and will therefore also help stabilize premiums and improve hospital wait times for ALL Marylanders.

While the state has recently made historic gains in health insurance coverage, Black, Latino, and Asian American Marylanders remain disproportionately represented among the uninsured. Immigration status can be a significant barrier to coverage. Removing immigration status as a barrier to health coverage is a matter of health equity and will establish a more fair and just health benefit exchange.

On behalf of the hundreds of organizations that make up the Maryland Health Care for All! Coalition, we applaud this 1332 waiver amendment application and ask that CMS quickly approve it to improve access to quality, affordable health care for all Marylanders.

2600 St. Paul Street Baltimore, MD 21218
www.healthcareforall.com
Phone (410)235-9000 Fax (410)235-9000

5750 Executive Drive, Suite 100, Baltimore, MD 21228
410.788.1066 » nasw-md.org

NASW MARYLAND CHAPTER
National Association of Social Workers

To: **U.S. Department of Health and Human Services and the Department of the Treasury**

Subject: **Support of MHBE's 1332 Waiver Amendment Application**

Date: **September 20, 2024**

The National Association of Social Workers – Maryland Chapter is the professional organization representing over 3,000 social workers statewide. MHBE's 1332 waiver amendment application which would allow people, who do not have legal residency status in Maryland, to purchase insurance on the Maryland Health Benefit Exchange. This waiver would permit those individuals to take advantage of Navigators who would make the health insurance purchasing process understandable and easier.

It is a known fact that health outcomes for immigrants are very poor as they tend to not seek out care due to their fear of being asked about their immigration status. We want them to know and understand that in the state of Maryland that is not the case. They live in an open and welcoming state that cares about their well-being.

We believe this waiver amendment is good first step in addressing a number of issues going forward. We already have the infrastructure in place and expanding access to health coverage will result in a healthier Maryland. Implementing the waiver amendment will help in getting people into the appropriate health care program of their choosing by unlocking barriers.

Karessa Proctor, BSW, MSW
Executive Director, NASW-MD

Philip A. Pratt, MSW, ACSW
Legislative Committee, Co-Chair

September 20, 2024

The Honorable Xavier Becerra
Secretary of Health and Human Services
Department of Health and Human Services
200 Independence Avenue, SW
Washington, D.C. 20201

The Honorable Janet Yellen
Secretary of the Treasury
Department of the Treasury
1500 Pennsylvania Avenue, NW
Washington, D.C. 20220

Submitted via email: stateinnovationwaivers@cms.hhs.gov

Re: Support for Maryland's 1332 Waiver Application

Dear Secretary Becerra and Secretary Yellen:

The undersigned organizations write in strong support of Maryland's Section 1332 Waiver Application (waiver) as one of the most promising opportunities to improve health coverage for Maryland residents since the passage of the Affordable Care Act (ACA). In Maryland today, many immigrants go without critical health care because they are ineligible for affordable health coverage. Over 164,000 of Maryland's immigrant residents lack insurance today due to this systemic inequity.

Maryland's immigrant communities need access to health care. Nearly seventeen percent of the people residing in Maryland are non-citizens. Over seventy-two percent of Maryland's foreign-born adults participate in the labor force, and they are over-represented in high-risk and physically demanding jobs. Despite their vital economic, cultural and social contributions, over thirty-five percent of Maryland's non-citizens, have no health insurance coverage.

The waiver aligns with the administration's priorities. President Biden has made important commitments to addressing racial disparities. On his first day in office, he signed Executive Order 13985, Advancing Racial Equity and Support for Underserved Communities Through the Federal Government. He subsequently signed Executive Order 14070, Continuing to Strengthen Americans' Access to Affordable, Quality Health Coverage, which states that it is the administration's policy to "make high-quality healthcare accessible and affordable for every American."

This waiver directly addresses racial health disparities by providing access for communities of color who are disproportionately denied access to affordable health coverage. It would allow Maryland to remove federal barriers to health coverage and to offer all Maryland residents the same opportunity to use the Maryland Health Benefits Exchange tools to learn about and compare health plans.

As demonstrated in the application, the waiver satisfies Section 1332's guardrails while proposing an innovative state policy solution. We strongly support Maryland's efforts to secure the federal flexibility needed to achieve improved health equity and respectfully ask that you expeditiously review and approve its 1332 waiver application.

Respectfully submitted,

ACLU of Maryland

ACQ Climate

Advance Maryland

Asian Resources, Inc.

Association of Asian Pacific Community Health Organizations (AAPCHO)

Baptist Ministers Night Conference of Baltimore & Vicinity

California Rural Legal Assistance Foundation (CRLA Foundation)

CATA/Farmworkers Support Committee

Cedar lane Unitarian Universalist Environmental Justice Ministry

Center for Law and Social Policy (CLASP)

Chesapeake Climate Action Network

Columbia Democratic Club

Community Catalyst

Congregation Action Network

Dr. P Solutions Services

East Bay Sanctuary Covenant

Governance Alive

Health Care Voices

HeartSmart Foundation

High Note Consulting, LLC

Illinois Coalition for Immigrant and Refugee Rights

Immigrant Justice Ministry of Cedar Lane Unitarian Universalist Congregation

Immigrant Justice Team, River Road UU Congregation

Indivisible Central Maryland

Jews United for Justice

La Clinica del Pueblo

La clínica del pueblo

League of United Latin American Citizens (LULAC)

Maryland Center on Economic Policy

Maryland Health Care for All! Coalition

Maryland Latinos Unidos (MLU)

Maryland Legislative Latino Caucus

MomsRising

NAMI Maryland (The National Alliance on Mental Illness)

National Asian Pacific American Women's Forum

National Latina Institute for Reproductive Justice

Pacific Asian Counseling Services

Prevention Institute

Public Justice Center

Sauti Yetu Center for African Women

SEIU local 32BJ

Shriver Center on Poverty Law

South Bay People Power

The Episcopal Diocese of Maryland

UnidosUS

Unitarian Universalist Legislative Ministry of MD

United We Dream

Young Center for Immigrant Children’s Rights

NATIONAL IMMIGRATION LAW CENTER

September 17, 2024

The Honorable Xavier Becerra
Secretary of Health and Human Services
Department of Health and Human Services
200 Independence Avenue, SW
Washington, D.C. 20201

The Honorable Janet Yellen
Secretary of the Treasury
Department of the Treasury
1500 Pennsylvania Avenue, NW
Washington, D.C. 20220

Submitted via email: stateinnovationwaivers@cms.hhs.gov

Re: National Immigration Law Center Support for Maryland's 1332 Waiver Application

Dear Secretary Becerra and Secretary Yellen:

The National Immigration Law Center (NILC) appreciates the opportunity to provide comments on Maryland's Section 1332 Waiver Application (waiver). We write in strong support of the waiver as one of the most promising opportunities to improve health coverage for Maryland residents since the passage of the Affordable Care Act (ACA).

Founded in 1979, NILC is an organization exclusively dedicated to defending and advancing the rights and opportunities of low-income immigrants and their families. We believe that all people should have the opportunity to achieve their full human potential – regardless of their race, gender, immigration, and/or economic status. For over 40 years, NILC has focused on issues that affect the well-being and economic security of low-income immigrants: healthcare and safety net programs; education and training; workers' rights; and other federal and state policies. When necessary, NILC has successfully defended the fundamental and constitutional rights of low-income immigrants and their families in litigation. NILC is one of the nation's leading substantive experts on immigrant eligibility and access to federal and state public benefits programs, including issues related to Medicaid and the ACA.

www.nilc.org

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Maryland is Home to Vibrant, and Rapidly Growing Immigrant Communities Who Need Access to Health Coverage

Nearly seventeen percent of the people residing in Maryland are non-citizens. Maryland's non-citizen population has grown at a remarkable pace, increasing by almost ninety-nine percent between the years 2000 and 2022.[i] Over seventy-two percent of Maryland's foreign-born adults participate in the labor force, and they are over-represented in high-risk and physically demanding jobs.[ii] Despite their vital economic, cultural and social contributions, over thirty-five percent of Maryland's non-citizens have no health insurance coverage. [iii]

This Waiver Aligns with the Administration's Priorities

President Biden has made important commitments to addressing racial disparities. On his first day in office, he signed Executive Order 13985, Advancing Racial Equity and Support for Underserved Communities Through the Federal Government. He subsequently signed Executive Order 14070, Continuing to Strengthen Americans' Access to Affordable, Quality Health Coverage, which states that it is the administration's policy to "make high-quality healthcare accessible and affordable for every American."

Immigrants' exclusion from healthcare affordability programs exacerbates racial health disparities. Maryland's foreign-born population is largely comprised of people of color, including:

- 31.4% Latinos,
- 26.9% Asians/Pacific Islanders, and
- 26.1% Blacks/African Americans.[iv]

This waiver directly addresses racial health disparities by providing access for communities of color who are disproportionately denied access to affordable health coverage.

The proposed waiver also aligns with the Administration's priority of reducing maternal mortality, a problem that disproportionately affects Black women.[v] As stated in the Whitehouse Blueprint for Addressing the Maternal Health Crisis, "Working to ensure that every person has access to comprehensive health care coverage and high-quality health care services, regardless of where they live or how much they earn, is critical to ending the maternal health crisis."[vi] By expanding access to comprehensive coverage for noncitizen and mixed-status families, this waiver will allow more Maryland residents to access to critical pre- and post-natal care and promote early diagnosis and treatment of conditions that can compromise pregnancy outcomes.

We strongly support Maryland's proposed waiver because it offers a pathway to a healthier future. The waiver would:

- allow Maryland to remove federal barriers to health coverage, offering all Maryland residents the same opportunity to use the Maryland Health Benefits Exchange tools to

learn about and compare health plans;

- give families with mixed immigration status the opportunity to enroll in one plan and share the same deductible;
- improve the broader individual insurance market by reducing application barriers that prevent families from applying for coverage together; and
- improve health equity by addressing one of the root causes of the disproportionate uninsurance rates and poorer health outcomes many of Maryland's communities of color face today.

In Maryland today, many immigrants go without critical health care because they are ineligible for affordable health coverage. Over 164,000 of Maryland's immigrant residents lack insurance today due to this systemic inequity.[vii]

Compared to people with health insurance, people who are uninsured have lower access to care and are more likely to delay or forgo care due to costs. Studies repeatedly demonstrate that uninsured people are less likely than those with insurance to receive preventive care and services for major health conditions and chronic diseases. When they do seek care, uninsured people often face unaffordable medical bills. In 2022, uninsured nonelderly adults were nearly twice as likely as those with insurance to say they have difficulty affording health care costs.[viii] Maryland's residents cannot wait for coverage any longer.

We urge you to approve the waiver. Maryland's waiver aligns with the stated goal of Affordable Care Act Section 1332, "to pursue innovative strategies for providing residents with access to high quality, affordable health insurance while retaining the basic protections of the ACA." As demonstrated in the application, the waiver satisfies Section 1332's guardrails while proposing an innovative state policy solution.

We strongly support Maryland's efforts to secure the federal flexibility needed to achieve improved health equity and respectfully ask that you expeditiously review and approve its 1332 waiver application. Thank you for your consideration. Please contact me at lessard@nilc.org with any questions.

Sincerely,

/s
Gabrielle Lessard
Senior Counsel

---

[i] Migration Policy Institute analysis of American Communities Survey data, available at https://www.migrationpolicy.org/data/state-profiles/state/demographics/MD/US

[ii] State of the Economy Series: Immigration and the Economy (Comptroller of Maryland April 2024), https://marylandtaxes.gov/reports/static-files/research/immigration-economy.pdf

[iii] Migration Policy Institute, supra note i.
[iv] Ibid.
[v] *See:* https://www.cdc.gov/womens-health/features/maternal-mortality.html#
[vi] Whitehouse Blueprint for Reducing Maternal Mortality (June 2022), https://www.whitehouse.gov/wp-content/uploads/2022/06/Maternal-Health-Blueprint.pdf
[vii] Migration Policy Institute, supra note i.
[viii] Jennifer Tolbert, Patrick Drake, and Anthony Damico, Key Facts about the Uninsured Population (KFF Dec. 18, 2023), https://www.kff.org/uninsured/issue-brief/key-facts-about-the-uninsured-population/#:~:text=People%20without%20insurance%20coverage%20have,difficulty%20affording%20health%20care%20costs.

September 20, 2024

The Honorable Janet Yellen
Secretary
Department of the Treasury
1500 Pennsylvania Avenue, NW
Washington, DC 20220

The Honorable Xavier Becerra
Secretary
Department of Health and Human Services
200 Independence Avenue, SW
Washington, DC 20201

Re: Maryland Section 1332 State Innovation Waiver Amendment Request

Dear Secretary Yellen and Secretary Becerra:

Thank you for the opportunity to provide feedback on Maryland's State Innovation Waiver Amendment Request.

The undersigned organizations represent millions of individuals facing serious, acute and chronic health conditions. We have a unique perspective on what individuals and families need to prevent disease, cure illness and manage chronic health conditions. The diversity of our organizations and the populations we serve enable us to draw upon a wealth of knowledge and expertise that is an invaluable resource regarding any decisions affecting the Affordable Care Act, the marketplace, and the people that they serve. We urge the Department of the Treasury and the Department of Health and Human Services (the Departments) to make the best use of the recommendations, knowledge and experience our organizations offer here.

Our organizations are committed to ensuring that Maryland's healthcare programs provide quality and affordable healthcare coverage. We believe that Maryland's proposal to use a Section 1332 waiver to allow all Marylanders, regardless of immigration status, to enroll in marketplace coverage will advance these objectives. Once implemented, this waiver amendment is expected to provide access to comprehensive marketplace coverage to thousands of Marylanders while satisfying the federal guardrail protections governing waivers, and we urge the Departments to approve this request.

Our organizations support Maryland's efforts to improve health equity by making affordable coverage available to all Marylanders, regardless of immigration status. Waiving Section 1312(f)(3) of the Affordable Care Act will make it easier for more Marylanders to access the care they need. This will enable more families with mixed immigration status to enroll in coverage together, and for uninsured individuals with no other options for health coverage to enroll in coverage as well. Those who enroll in coverage due to this amendment will also have access to other benefits available through the marketplace, including language interpretation services.

At the same time, the state represents that the waiver will not affect comprehensiveness of benefits or costs for existing marketplace enrollees, satisfying federal statutory guardrails. We appreciate the commitment to preserving affordability and access to comprehensive coverage for the more than 200,000 current enrollees of the program.

While Maryland anticipates that this amendment will gradually increase enrollment, the cost of marketplace plans may still be a barrier to accessing coverage for this population. Our organizations have encouraged Maryland to establish a state subsidy program for the population that this amendment would impact. Research consistently shows that higher cost-sharing is associated with decreased use of preventive services and medical care among low-income populations.[1] A subsidy program would improve affordability of care and drive coverage enrollment in Maryland, while also bolstering health equity. Nationally, 18% of lawfully present immigrants and half of undocumented immigrants report being uninsured, compared to 8% of US-born citizens, and this population is also more likely to report facing coverage barriers and skipping care.[2] By expanding financial assistance for marketplace plans, Maryland can raise enrollment among underserved populations, improving health equity and reducing disparities.

Our organizations support this proposal to expand access to quality coverage in Maryland and urge the Departments to approve it while encouraging the state implement a subsidy program that would improve affordability of coverage. Thank you for the opportunity to provide comments.

Sincerely,

American Cancer Society Cancer Action Network
American Lung Association
Asthma and Allergy Foundation of America
Cancer*Care*
Hemophilia Federation of America
National Patient Advocate Foundation
Susan G. Komen
The AIDS Institute
The Leukemia & Lymphoma Society
WomenHeart

[1]Artiga, Samantha et al. The Effects of Premiums and Cost Sharing on Low-Income Populations: Updated Review of Research Findings. KFF. June 1, 2017. Available at: https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/.

[2] Key Facts on Health Coverage of Immigrants. KFF. September 1, 2023. Available at: https://www.kff.org/racial-equity-and-health-policy/fact-sheet/key-facts-on-health-coverage-of-immigrants/.

KFF

The independent source for health policy research, polling, and news.

The Effects of Premiums and Cost Sharing on Low-Income Populations: Updated Review of Research Findings

Samantha Artiga (https://www.kff.org/person/samantha-artiga/), **Petry Ubri, and Julia Zur**

Published: Jun 01, 2017

ISSUE BRIEF

Key Findings

Recently, there has been increased interest at the federal and state level to expand the use of premiums and cost sharing in Medicaid as a way to promote personal responsibility, prepare beneficiaries to transition to commercial and private insurance, and support consumers in making value-conscious health decisions. This brief reviews research from 65 papers published between 2000 and March 2017 on the effects of premiums and cost sharing on low-income populations in Medicaid and CHIP. This research has primarily focused on how premiums and cost sharing affect coverage and access to and use of care; some studies also have examined effects on safety net providers and state savings. The effects on individuals, providers, and state costs reflect varied implementation of premiums and cost sharing across states as well as differing premium and cost sharing amounts. Together, the research finds:

- **Premiums serve as a barrier to obtaining and maintaining Medicaid and CHIP coverage among low-income individuals.** These effects are largest among those with the lowest incomes, particularly among individuals with incomes below poverty. Some individuals losing Medicaid or CHIP coverage move to other coverage, but others become uninsured, especially those with lower incomes. Individuals who become uninsured face increased barriers to accessing care, greater unmet health needs, and increased financial burdens.
- **Even relatively small levels of cost sharing in the range of $1 to $5 are associated with reduced use of care, including necessary services.** Research also finds that cost sharing can result in unintended consequences, such as increased use of the emergency room, and that cost sharing negatively affects access to care and health outcomes. For example, studies find that increases in cost sharing are associated with increased rates of uncontrolled hypertension and hypercholesterolemia and reduced treatment for children with asthma. Additionally, research finds that cost sharing increases financial burdens for families, causing some to cut back on necessities or borrow money to pay for care.
- **State savings from premiums and cost sharing in Medicaid and CHIP are limited.** Research shows that potential revenue gains from premiums and cost sharing are offset by increased disenrollment; increased use of more expensive services, such as emergency room care; increased costs in other areas, such as resources for uninsured individuals; and administrative expenses. Studies also show that raising premiums and cost sharing in Medicaid and CHIP increases pressures on safety net providers, such as community health centers and hospitals.

Introduction

Recently, there has been increased interest at the federal and state level to expand the use of premiums and cost sharing in Medicaid. Current rules limit premiums and cost sharing in Medicaid to facilitate access to coverage and care for the low-income population served by the program, who have limited resources to spend on out-of-pocket costs. Proponents of increasing premiums and cost sharing in Medicaid indicate that doing so will promote personal responsibility, prepare beneficiaries to transition to commercial and private insurance, and support consumers in making value-conscious health decisions.[1] (https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-1)

This brief, which updates an earlier brief "*Premiums and Cost-Sharing in Medicaid: A Review of Research Findings* (https://www.kff.org/medicaid/issue-brief/premiums-and-cost-sharing-in-medicaid-a-review-of-research-findings/)," reviews research on the effects of premiums and cost sharing on low-income populations in Medicaid and CHIP. It draws on findings from 65 papers published between 2000 and March 2017, including peer-reviewed studies and freestanding reports, government reports, and white papers by research and policy organizations. This research has primarily focused on how premiums and cost sharing affect coverage and access to care; some studies also have examined effects on state savings. The effects on individuals, providers, and state costs reflect varied implementation of premiums and cost sharing across states as well as differing premium and cost sharing amounts.

Premiums and Cost Sharing in Medicaid and CHIP Today

Currently, states have options to charge premiums and cost sharing in Medicaid and CHIP that vary by income and eligibility group (Box 1). Reflecting these options, premiums and cost sharing in Medicaid and CHIP vary across states and groups. As of January 2017, 30 states charge premiums or enrollment fees and 25 states charge cost sharing for children in Medicaid or CHIP.[2] (https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-2) Most of these charges are limited to children in CHIP since the program covers children with higher family incomes than Medicaid and has different premium and cost sharing rules. States generally do not charge premiums for parents in Medicaid, but 39 states charge cost sharing for parents and 23 of the 32 states that implemented the Affordable Care Act (ACA) Medicaid expansion to low-income adults charge cost sharing for expansion adults.[3] (https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-3) Six states have waivers to charge premiums or monthly contributions for adults that are not otherwise allowed.[4] (https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-4)

Box 1: Medicaid and CHIP Premium and Cost Sharing Rules

Medicaid

- States may charge premiums for enrollees with incomes above 150% of the federal poverty level (FPL), including children and adults. Enrollees with incomes below 150% FPL may not be charged premiums.
- States may charge cost sharing up to maximums that vary by income (Table 1). States cannot charge cost sharing for emergency, family planning, pregnancy-related services, preventive services for children, or preventive services defined as essential health benefits in Alternative Benefit Plans in Medicaid. In addition, states generally cannot charge cost sharing to children enrolled through mandatory eligibility categories. The minimum eligibility standard for children is 133% FPL, although some states have higher minimums.
- Overall, premium and cost sharing amounts for family members enrolled in Medicaid may not exceed 5% of household income. This 5% cap is applied on a monthly or quarterly basis.

CHIP

- States have somewhat greater flexibility to charge premiums and cost sharing for children in CHIP, although there are limits on the amounts that states can charge, including an overall cap of 5% of household income.

Table 1: Maximum Allowable Cost Sharing Amounts in Medicaid by Income

	<100% FPL	100% – 150% FPL	>150% FPL
Outpatient Services	$4	10% of state cost	20% of state cost
Non-Emergency use of ER	$8	$8	No limit (subject to overall 5% of household income limit)
Prescription Drugs			
Preferred	$4	$4	$4
Non-Preferred	$8	$8	20% of state cost
Inpatient Services	$75 per stay	10% of state cost	20% of state cost

Notes: Some groups and services are exempt from cost sharing, including children enrolled in Medicaid through mandatory eligibility pathways, emergency services, family planning services, pregnancy related services, and preventive services for children. Maximum allowable amounts are as of FY2014. Beginning October 1, 2015, maximum allowable amounts increase annually by the percentage increase in the medical care component of the Consumer Price Index for All Urban Consumers (CPI-U).

Effects of Premiums (Table 1 (https://www.kff.org/report-section/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings-table-1/))

A large body of research shows that premiums can serve as a barrier to obtaining and maintaining Medicaid and CHIP coverage among low-income individuals. Studies show that premiums in Medicaid and CHIP lead to a reduction in coverage among both children and adults.[5] (https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-5),[6] (https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-6),[7] (https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-7),[8] (https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-8),[9] (https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-9),[10] (https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-10) Numerous studies find that premiums increase disenrollment from Medicaid and CHIP among adults and children, shorten lengths of Medicaid and CHIP enrollment, and deter eligible adults and children from enrolling in Medicaid and CHIP.[11] (https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-11),[12] (https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-12),[13] (https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-13),[14] (https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-14),[15] (https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-15),[16] (https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-16),[17] (https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-17),[18] (https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-18),[19] (https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-

findings/view/footnotes/#footnote-220856-19)[20](https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-20)[21](https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-21)[22](https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-22)[23](https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-23)[24](https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-24)[25](https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-25)[26](https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-26)[27](https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-27)[28](https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-28)[29](https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-29)[30](https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-30)[31](https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-31)[32](https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-32)[33](https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-33)[34](https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-34)[35](https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-35)[36](https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-36)[37](https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-37)[38](https://www.kff.org/medicaid/issue-brief/the-effects-of-

premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-38)’[39] (https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-39)

Although some individuals who disenroll from Medicaid or CHIP following premium increases move to other sources of coverage, others become uninsured and face negative effects on their access to care and financial security. Those with lower incomes and those without a worker in the family are more likely to become uninsured compared to those with relatively higher incomes or with a worker in the family, reflecting less availability of employer coverage.[40] (https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-40)’[41] (https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-41)’[42] (https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-42)’[43] (https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-43)’[44] (https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-44)’[45] (https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-45)’[46] (https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-46)’[47] (https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-47)’[48] (https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-48)’[49] (https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-49) Studies also show that those who become uninsured following premium increases face increased barriers to accessing care, have greater unmet health needs, and face increased financial burdens.[50] (https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-50)’[51] (https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-51)’[52] (https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-52) ’[53] (https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-

populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-53)',[54] (https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-54) Several studies suggest that these negative effects on health care are largest among individuals with greater health care needs.[55] (https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-55)',[56] (https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-56)

Premium effects are largest for those with the lowest incomes, particularly among those with incomes below poverty. Given that most states limit premium charges to children in CHIP, most studies of premium effects have focused on children in CHIP, who generally have incomes above 100% or 150% of the federal poverty level. A range of these studies show that premium effects are larger among children at the lower end of this income range, who have greater disenrollment and increased likelihood of becoming uninsured.[57] (https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-57)',[58] (https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-58)',[59] (https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-59)',[60] (https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-60)',[61] (https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-61)',[62] (https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-62)',[63] (https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-63)',[64] (https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-64)',[65] (https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-65) Reflecting the more limited use of premiums among Medicaid enrollees with incomes below poverty, fewer studies have focused on this population. However, studies that have focused on poor Medicaid enrollees found substantial negative effects on enrollment from premiums.[66] (https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-66)',[67] (https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-

populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-67),[68] (https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-68),[69] (https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-69) For example, in Oregon, nearly half of adults disenrolled from Medicaid after a premium increase with a maximum premium amount of $20, with many becoming uninsured and facing barriers to accessing care, unmet health needs, and increased financial burdens.[70] (https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-70),[71] (https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-71),[72] (https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-72) Similarly, a more recent study of the Healthy Indiana Plan waiver program for Medicaid expansion adults with incomes below 138% FPL, which requires premiums that range from $1-$100 to enroll in a more comprehensive plan, found that 55% of eligible individuals either did not make their initial payment or missed a payment.[73] (https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-73) Research also finds that premium effects may vary by other factors beyond income. For example, one study finds larger effects of premiums among families without an offer of employer-sponsored coverage.[74] (https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-74) Some research also suggests that increases in Medicaid and CHIP premiums may have larger effects on coverage for children of color and among children whose families have lower levels of educational attainment.[75] (https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-75),[76] (https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-76),[77] (https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-77)

Research finds varying implications of premiums for individuals with significant health needs. Overall, individuals with greater health needs are less likely to disenroll from Medicaid or CHIP coverage and are more likely to have longer periods of Medicaid or CHIP coverage compared to those with fewer health needs.[78] (https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-78),[79] (https://www.kff.org/medicaid/issue-brief/the-effects-of-

premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-79)',[80] (https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-80)',[81] (https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-81) However, findings vary regarding how individuals with health needs respond to premium increases. Some studies show that individuals with greater health needs are less sensitive to premium increases compared to those with fewer health needs, reflecting their increased need for services.[82] (https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-82)',[83] (https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-83) These findings suggest that individuals with greater health needs are more likely than those with less significant health needs to remain enrolled following premium increases, but then face increased financial burdens to maintain their coverage. Other studies find that children with increased health needs are as likely or more likely than those with fewer health needs to disenroll from coverage following premium increases, suggesting premiums may lead to children going without coverage despite ongoing health needs.[84] (https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-84)',[85] (https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-85)

Effects of Cost Sharing (Table 2 (https://www.kff.org/report-section/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings-table-2/))

A wide range of studies find that even relatively small levels of cost sharing, in the range of $1 to $5, are associated with reduced use of care, including necessary services. The RAND health insurance experiment (HIE), conducted in the 1970s and still considered the seminal study on the effects of cost sharing on individual behavior, shows a reduction in use of services after cost sharing increased, regardless of income.[86] (https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-86) Since then, a growing body of research has found that cost sharing is associated with reduced utilization of services,[87] (https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-87) including vaccinations,[88] (https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-88) prescription drugs,[89] (https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-

sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-89)',[90] (https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-90)',[91] (https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-91)',[92] (https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-92) mental health visits,[93] (https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-93) preventive and primary care,[94] (https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-94)',[95] (https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-95)',[96] (https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-96)',[97] (https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-97)',[98] (https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-98) and inpatient and outpatient care,[99] (https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-99)',[100] (https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-100) and decreased adherence to medications.[101] (https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-101)',[102] (https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-102)',[103] (https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-103) In many of these studies, copayment increases as small as $1-$5 can effect use of care. Some studies find that lower-income individuals are more likely to reduce their use of services, including essential services, than higher-income individuals.[104] (https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-104)',[105] (https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-105) Research also suggests that copayments can result in unintended consequences, such as increased use of other costlier services like the emergency room.[106] (https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-

on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-106) Two studies have found that copayments do not negatively affect utilization.[107] (https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-107),[108] (https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-108) In one case, the authors suggest that increases in provider reimbursement may have negated effects of the copayment increases, particularly if not all copayments were being collected by providers at the point of care.[109] (https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-109)

Research points to varying effects of cost sharing for people with significant health needs. Some studies find that utilization among individuals with chronic conditions or significant health needs is less sensitive to copayments compared to those with fewer health needs. As such, these individuals face increased cost burdens associated with accessing care because of copayment increases.[110] (https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-110),[111] (https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-111) Other research finds that even relatively small copayments can reduce utilization among individuals with significant health needs.[112] (https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-112),[113] (https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-113),[114] (https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-114)

Numerous studies find that cost sharing has negative effects on individuals' ability to access needed care and health outcomes and increases financial burdens for families.[115] (https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-115),[116] (https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-116),[117] (https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-117),[118] (https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-118),[119] (https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-

populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-119)',[120] (https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-120)',[121] (https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-121)',[122] (https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-122) For example, studies have found that increases in cost sharing are associated with increased rates of uncontrolled hypertension and hypercholesterolemia[123] (https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-123) and reduced treatment for children with asthma.[124] (https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-124) Increases in cost sharing also increase financial burdens for families, causing some to cut back on necessities or borrow money to pay for care. In particular, small copayments can add up quickly when an individual needs ongoing care or multiple medications.[125] (https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-125)',[126] (https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-126)

Findings on how cost sharing affects non-emergent use of the emergency room are limited. One study found that these copayments reduce non-urgent visits.[127] (https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-127) Other studies find that these copayments do not affect use of the emergency room.[128] (https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-128)',[129] (https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-129)

Effects on State Budgets and Providers (Table 3 (https://www.kff.org/report-section/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings-table-3/))

Research suggests that state savings from premiums and cost sharing in Medicaid and CHIP are limited. Studies find that potential increases in revenue from premium and cost sharing are offset by increased disenrollment; increased use of more expensive services, such as emergency room care; increased costs in other areas, such as resources for

uninsured individuals; and administrative expenses.[130](https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-130),[131](https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-131),[132](https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-132),[133](https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-133),[134](https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-134),[135](https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-135),[136](https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-136) One state study found increased revenues from premiums without significant effects on enrollment, but authors note a range of program-specific factors that may have contributed to this finding, including it being limited to a Medicaid-buy in program for individuals with disabilities with incomes above 150% FPL who may be less price-sensitive to the increase and the state implementing administrative processes designed to minimize disenrollment.[137](https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-137)

Studies also show that increases in premiums and cost sharing in Medicaid and CHIP can increase pressures on safety net providers, such as community health centers and hospitals. Several studies show that coverage losses following premium increases lead to increases in the share of uninsured patients seen by providers[138](https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-138),[139](https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-139),[140](https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-140) and increased emergency department use by uninsured individuals.[141](https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-141),[142](https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-142) One study also found that increases in copayments led to community health centers having to divert resources for medications for uninsured

individuals to help people who could not afford copayments and that copayments increased the rate of "no shows" for appointments at community health centers.[143] (https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-143)

Conclusion

Recently, there has been increased interest at the federal and state levels to expand the use of premiums and cost sharing in Medicaid as a way to promote personal responsibility, prepare beneficiaries to transition to commercial and private insurance, and support consumers in making value-conscious health decisions. Current rules limit premiums and cost sharing in Medicaid to facilitate access to coverage and care for the low-income population served by the program, who have limited resources to spend on out-of-pocket costs. This review of a wide body of research provides insight into the potential effects of increasing premiums and cost sharing for Medicaid enrollees. It shows that premiums serve as a barrier to obtaining and maintaining coverage for low-income individuals, particularly those with the most limited incomes, and that even relatively small levels of cost sharing reduce utilization of services. As such, increases in premiums and cost sharing result in increased barriers to coverage and care, greater unmet health needs, and increased financial burdens for families. Further, the research suggests that state savings from premiums and cost sharing in Medicaid and CHIP are limited and that increases in premiums and cost sharing in Medicaid and CHIP can increase pressures on safety-net providers.

STUDY TABLES (HTTPS://WWW.KFF.ORG/REPORT-SECTION/THE-EFFECTS-OF-PREMIUMS-AND-COST-SHARING-ON-LOW-INCOME-POPULATIONS-UPDATED-REVIEW-OF-RESEARCH-FINDINGS-STUDY-TABLES/) ›

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Key Facts on Health Coverage of Immigrants

Published: Sep 17, 2023

Note: This content was updated on June 26, 2024 to include updated information about state coverage for immigrants.

Summary

As of 2022, there were 45.5 million immigrants residing in the U.S., including 21.2 million noncitizen immigrants and 24.2 million naturalized citizens, who each accounted for about 7% of the total population.[1] Noncitizens include lawfully present and undocumented immigrants. Many individuals live in mixed immigration status families that may include lawfully present immigrants, undocumented immigrants, and/or citizens. One in four children has an immigrant parent, including over one in ten (12%) who are citizen children with at least one noncitizen parent.[2] This fact sheet provides an overview of health coverage for immigrants based on data from The 2023 KFF/LA Times Survey of Immigrants (https://www.kff.org/racial-equity-and-health-policy/issue-brief/health-and-health-care-experiences-of-immigrants-the-2023-kff-la-times-survey-of-immigrants), the largest nationally representative survey focused on immigrants.

As of 2023, half (50%) of likely undocumented immigrant adults and one in five (18%) lawfully present immigrant adults report being uninsured compared to less than one in ten naturalized citizen (6%) and U.S.-born citizen (8%) adults.[3] Noncitizen immigrants are more likely to be uninsured than citizens because they have more limited access to private coverage due to working in jobs (https://www.kff.org/racial-equity-and-health-policy/issue-brief/employment-among-immigrants-and-implications-for-health-and-health-care/) that are less likely to provide health benefits and they face eligibility restrictions for federally funded coverage options, including Medicaid, the Children's Health Insurance Program (CHIP), Affordable Care Act (ACA) Marketplace coverage, and Medicare. Those who are eligible for coverage also face

a range of enrollment barriers including fear, confusion about eligibility rules, and language and literacy challenges. Reflecting their higher uninsured rate, noncitizen immigrants are more likely than citizens to report barriers to accessing health (https://www.kff.org/racial-equity-and-health-policy/issue-brief/health-and-health-care-experiences-of-immigrants-the-2023-kff-la-times-survey-of-immigrants) care and skipping or postponing care. Immigrants have lower health care expenditures (http://www.pnhp.org/docs/ImmigrationStudy_IJHS2018.pdf) than their U.S.-born counterparts given their more limited access and use.

Some states have expanded access to health coverage for immigrants. At the federal level, legislation (https://www.congress.gov/bill/118th-congress/senate-bill/2646?s=5&r=5) has been proposed that would expand eligibility for health coverage for immigrants, though it faces no clear path to passage in Congress. At the state level, there has been continued take up of state options to expand Medicaid and CHIP coverage for lawfully present immigrant children and pregnant people, and a small but growing number of states have expanded fully state-funded coverage to certain groups of low-income people regardless of immigration status. However, many immigrants, particularly those who are undocumented, remain ineligible for coverage options.

Many immigrants remain fearful of accessing assistance programs, including health coverage. The Biden Administration reversed prior Trump Administration changes to public charge rules (https://www.kff.org/racial-equity-and-health-policy/issue-brief/2022-changes-to-the-public-charge-inadmissibility-rule-and-the-implications-for-health-care/), which may help reduce fears among immigrant families about participating in non-cash assistance programs, including Medicaid and CHIP. It also increased funding (https://www.kff.org/private-insurance/issue-brief/navigator-funding-restored-in-federal-marketplace-states-for-2022/) for Navigator programs that provide enrollment assistance to individuals, which is particularly important for helping immigrant families enroll in coverage. However, as of 2023, nearly three-quarters (https://www.kff.org/racial-equity-and-health-policy/issue-brief/health-and-health-care-experiences-of-immigrants-the-2023-kff-la-times-survey-of-immigrants) of immigrant adults, including nine in ten of those who are likely undocumented, report uncertainty about how use of non-cash assistance programs may impact immigration status or incorrectly believe use may reduce the chances of getting a green card in the future. About a quarter (27%) of likely undocumented immigrants and nearly one in ten (8%) lawfully present immigrants say they avoided applying for food, housing, or health care assistance in the past year due to immigration-related fears.

Overview of Immigrants

Based on federal survey data, as of 2022, there were 45.5 million immigrants residing in the U.S., including 21.2 million noncitizens and 24.2 million naturalized citizens, who each accounted for about 7% of the total population (Figure 1).[4] About six in ten noncitizens were lawfully present immigrants, such as lawful permanent residents (green card holders) and those with a valid work or student visa, while the remaining four in ten

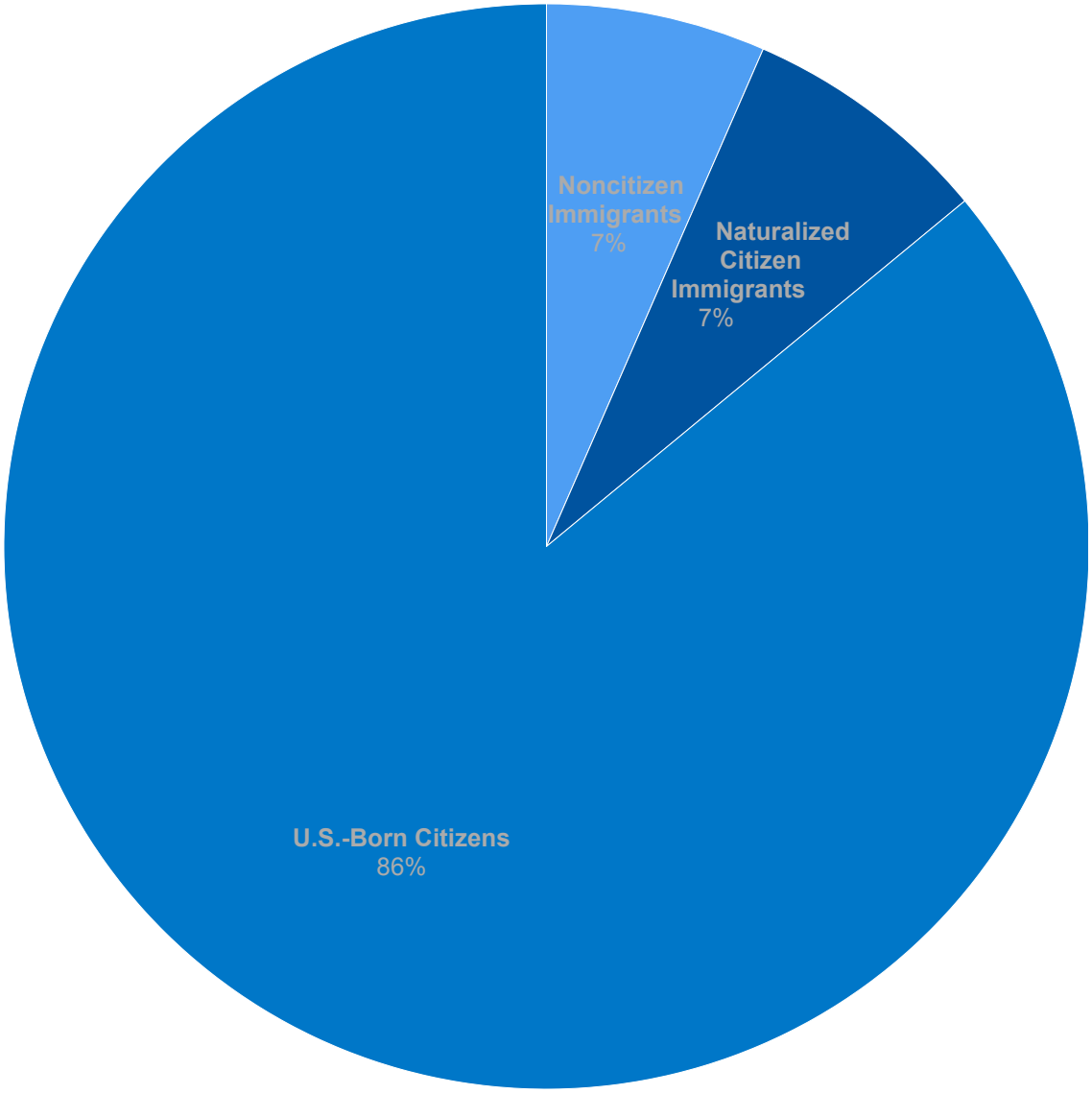
were undocumented immigrants, who may include individuals who entered the country without authorization and individuals who entered the country lawfully and stayed after their visa or status expired.[5] Many individuals live in mixed immigration status families that may include lawfully present immigrants, undocumented immigrants, and/or citizens. A total of 19 million or one in four children living in the U.S. had an immigrant parent as of 2022, and the majority of these children were citizens (Figure 1).[6] About 8.6 million or 12% were citizen children with at least one noncitizen parent.

Figure 1

Immigrants as a Share of the Total U.S. Population, 2022

Total U.S. Population: 324.5 Million

Total U.S. Population | Total Children



NOTE: Totals may not sum to 100% due to rounding.

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Uninsured Rates by Immigration Status

The 2023 KFF/LA Times Survey of Immigrants (https://www.kff.org/racial-equity-and-health-policy/issue-brief/health-and-health-care-experiences-of-immigrants-the-2023-kff-la-times-survey-of-immigrants), the largest nationally representative survey focused on immigrants, provides data on health coverage of immigrant adults and experiences accessing health care, including by immigration status.

Although the majority of uninsured people (https://www.kff.org/uninsured/report/the-uninsured-and-the-aca-a-primer-key-facts-about-health-insurance-and-the-uninsured-amidst-changes-to-the-affordable-care-act/) **are citizens, noncitizen immigrants, particularly likely undocumented immigrants, are significantly more likely to report being uninsured than citizens.** As of 2023, half (50%) of likely undocumented immigrants and one in five (18%) lawfully present immigrants say they are uninsured compared to 6% of naturalized citizens and 8% of U.S.-born citizens (Figure 2).[7]

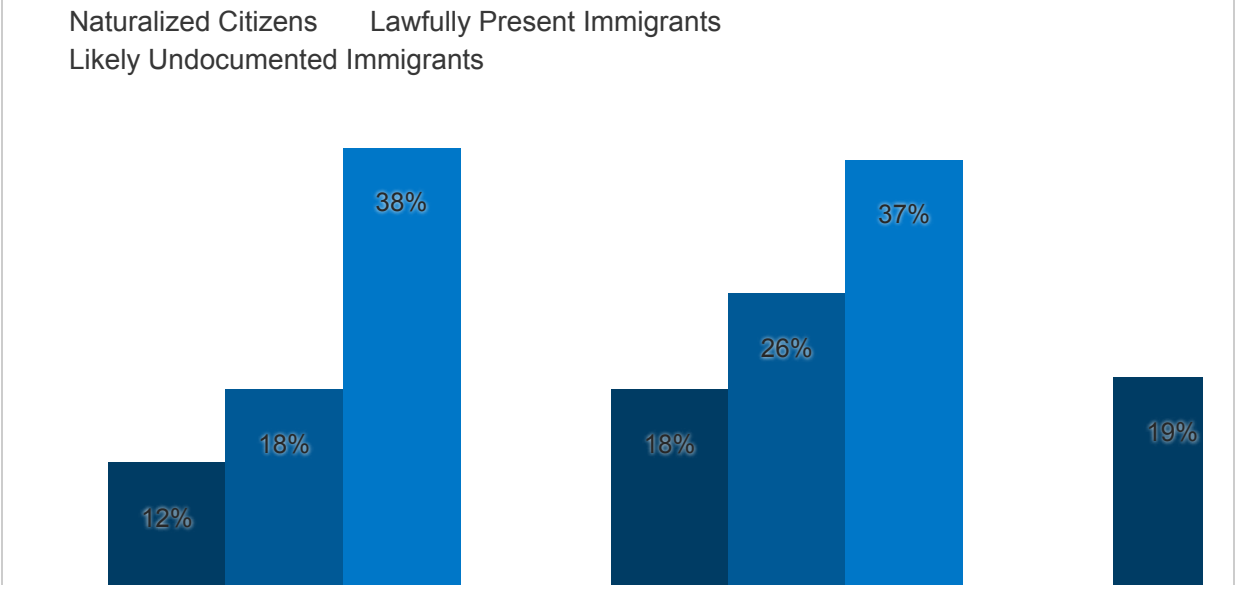
Figure 2

Uninsured Rates among U.S. Adults by Citizenship and Immigration Status, 2023

Reflecting their higher uninsured rates, noncitizen immigrants, especially those who are likely undocumented, are more likely than citizens to report barriers to accessing health care and skipping or postponing care. Research shows that having insurance makes a difference in whether and when people access needed care. Those who are uninsured often delay (https://www.kff.org/report-section/the-uninsured-and-the-aca-a-primer-key-facts-about-health-insurance-and-the-uninsured-amidst-changes-to-the-affordable-care-act-how-does-lack-of-insurance-affect-access-to-care/) or go without needed care, which can lead to worse health outcomes over the long-term that may ultimately be more complex and expensive to treat**.** Overall, likely undocumented immigrants are more likely than lawfully present immigrants and naturalized citizens to report not having a usual source of care other than an emergency room, not having a doctor's visit in the past 12 months, and skipping or postponing care in the past 12 months (Figure 3).[8] Lawfully present immigrants also are more likely than naturalized citizens to say they have not had a doctor's visit in the past 12 months.

Figure 3

Health Care Access and Use among Immigrant Adults by Immigration Status, 2023



Research also shows that immigrants have lower (http://www.pnhp.org/docs/ImmigrationStudy_IJHS2018.pdf) health care expenditures than their U.S.-born counterparts as a result of lower health care access and use, although their out-of-pocket payments tend to be higher due to higher uninsured rates. Recent research further finds that, because immigrants, especially undocumented immigrants, have lower health care use despite contributing billions of dollars in insurance premiums and taxes, they help subsidize (https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2798221) the U.S. health care system and offset the costs of care incurred by U.S.-born citizens.

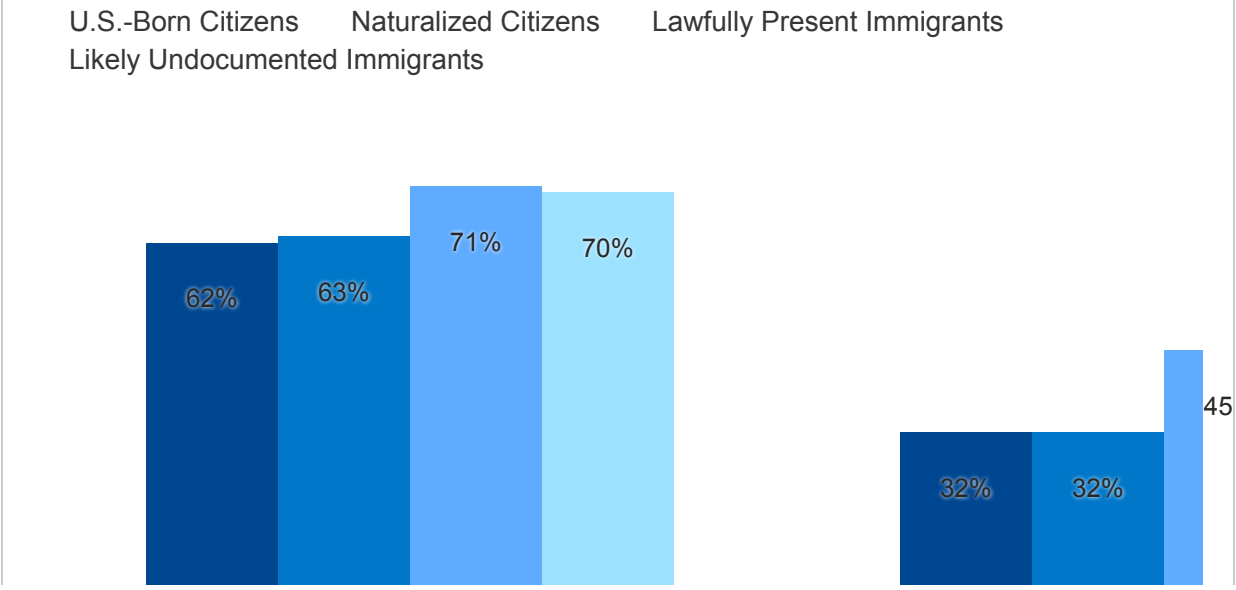
Access to Health Coverage Among Immigrants

Private Coverage

Despite high rates of employment, noncitizen immigrants have limited access to employer-sponsored coverage. Although most noncitizen immigrant adults say they are employed, they are significantly more likely than citizens to report being lower income (household income less than $40,000) (Figure 4).[9] This pattern reflects disproportionate employment of noncitizen immigrants in low-wage jobs and industries (https://www.kff.org/racial-equity-and-health-policy/issue-brief/employment-among-immigrants-and-implications-for-health-and-health-care/) that are less likely to offer employer-sponsored coverage. Given their lower incomes, noncitizen immigrants also face challenges affording employer-sponsored coverage when it is available or through the individual market.

Figure 4

Employment and Income Among U.S. Adults by Citizenship and Immigration Status, 2023



Federally Funded Coverage

Lawfully present immigrants may qualify for Medicaid and CHIP but are subject to certain eligibility restrictions. In general, lawfully present immigrants must have a "qualified" immigration status to be eligible for Medicaid or CHIP, and many, including most lawful permanent residents or "green card" holders, must wait five years after obtaining qualified status before they may enroll. Some immigrants with qualified status, such as refugees and asylees, as well as citizens of Compact of Free Association (COFA) communities, do not have to wait five years before enrolling. Some immigrants, such as those with temporary protected status, are lawfully present but do not have a qualified status and are not eligible to enroll in Medicaid or CHIP regardless of their length of time in the country (Appendix A). For children and pregnant people, states can eliminate the five-year wait and extend coverage to lawfully present immigrants without a qualified status. As of March 2024, 37 states (https://www.kff.org/racial-equity-and-health-policy/issue-brief/state-health-coverage-for-immigrants-and-implications-for-health-coverage-and-care/) plus D.C. have taken up this option for children and 30 states plus D.C. have elected the option for pregnant individuals.

In December 2020, Congress restored Medicaid eligibility for citizens of COFA communities and in March 2024 (https://www.congress.gov/bill/118th-congress/house-bill/4366), eligibility was restored for additional federally funded programs including CHIP. The U.S. government has COFA agreements with the Republic of the Marshall Islands, the Federated States of Micronesia, and the Republic of Palau. Certain citizens of these nations can lawfully work, study, and reside in the U.S., but they had been excluded from federally funded Medicaid since 1996, under the Personal Responsibility and Work Opportunity

Reconciliation Act. As part of a COVID-relief package, Congress restored Medicaid eligibility for COFA citizens who meet other eligibility requirements for the program effective December 27, 2020. On March 9, 2024, Congress further extended eligibility for COFA citizens to newly include other federally funded programs such as CHIP, the Supplemental Nutrition Assistance Program (SNAP), and Temporary Assistance for Needy Families (TANF), among others.

A total of 22 states have also extended coverage to pregnant people regardless of immigration status through the CHIP From-Conception-to-End-of-Pregnancy (https://www.kff.org/report-section/medicaid-and-chip-eligibility-enrollment-and-renewal-policies-as-states-prepare-for-the-unwinding-of-the-pandemic-era-continuous-enrollment-provision-report/#MedicaidandCHIPEligibility) **(FCEP) option**. Colorado (https://leg.colorado.gov/bills/hb22-1289) plans to implement this coverage by January 2025. While other pregnancy-related coverage in Medicaid and CHIP requires 60 days of postpartum coverage, the CHIP FCEP option does not include this coverage. However, some states that took up this option provide postpartum coverage regardless of immigration status either through a CHIP state plan amendment or using state-only funding. Additionally, ten states (California, Connecticut, Illinois, Maine, Massachusetts, Minnesota, New York, Oregon, Rhode Island, and Washington) have used state funding or CHIP health services initiatives to extend postpartum coverage to 12 months to individuals regardless of immigration status to align with the Medicaid extension (https://www.kff.org/policy-watch/postpartum-coverage-extension-in-the-american-rescue-plan-act-of-2021/) established by the American Rescue Plan Act, and Maryland extends coverage (https://health.maryland.gov/mmcp/medicaid-mch-initiatives/Pages/healthybabies.aspx) for four months postpartum through its health services initiative.

Lawfully present immigrants can purchase coverage through the ACA Marketplaces and, like citizens, may receive tax credits to help pay for premiums and cost sharing that vary on a sliding scale based on income. Generally, these tax credits are available to people with incomes starting from 100% of the federal poverty level (FPL) who are not eligible for other affordable coverage. In addition, lawfully present immigrants with incomes below 100% FPL may receive tax credits if they are ineligible for Medicaid based on immigration status. This group includes lawfully present immigrants who are not eligible for Medicaid or CHIP because they are in the five-year waiting period or do not have a “qualified” status.

Lawfully present immigrants also can qualify for Medicare (https://www.kff.org/faqs/medicare-open-enrollment-faqs/can-immigrants-enroll-in-medicare/) **subject to certain restrictions.** Specifically, they must have sufficient work history to qualify for premium-free Medicare Part A. If they do not have sufficient work history, they may qualify if they are lawful permanent residents and have resided in the U.S. for five years immediately prior to enrolling in Medicare, although they must pay premiums to enroll in Part A.

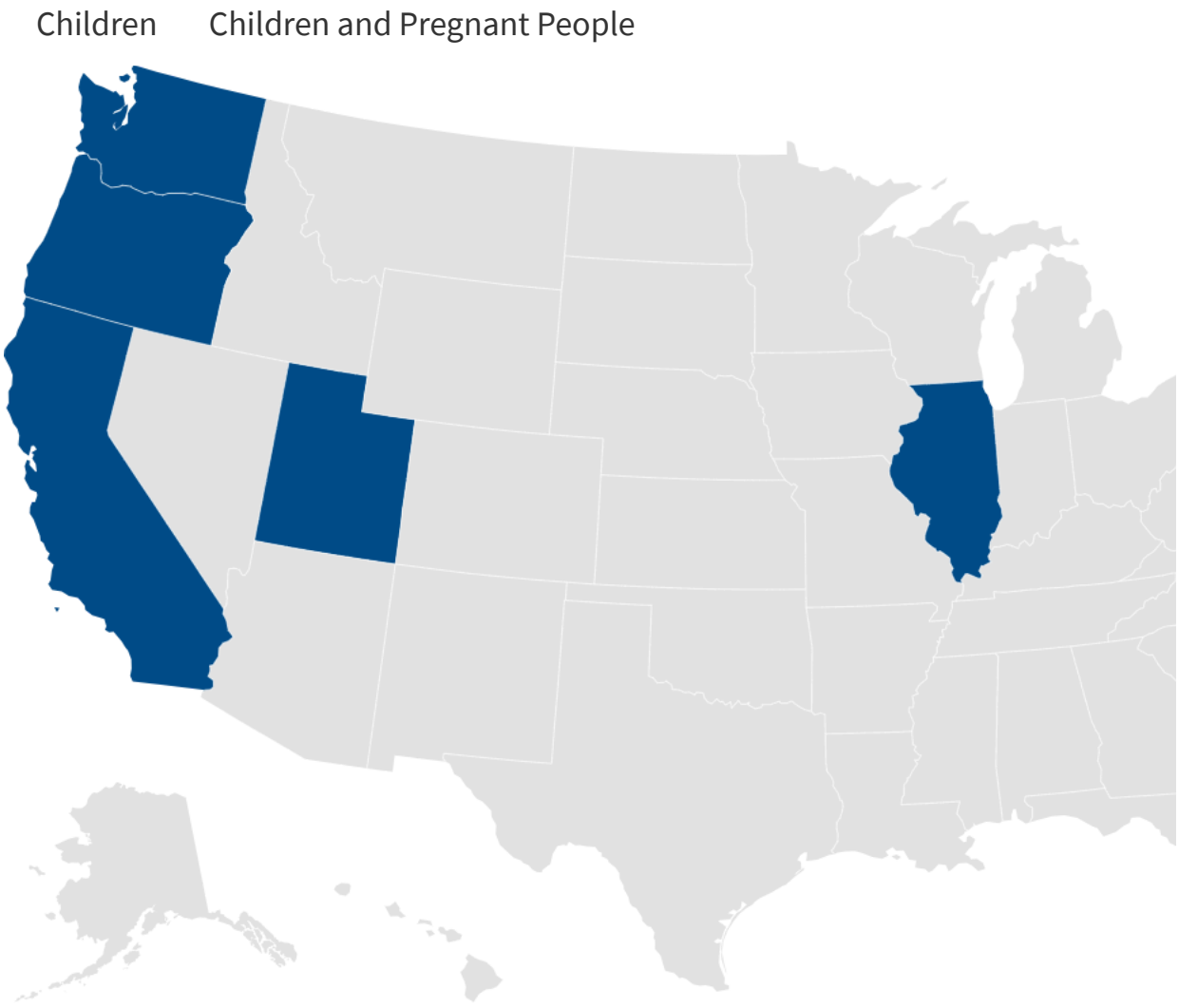
Undocumented immigrants are not eligible to enroll in federally funded coverage including Medicaid, CHIP, or Medicare or to purchase coverage through the ACA Marketplaces. Previously, individuals with Deferred Action for Childhood Arrivals (https://www.medicaid.gov/Federal-Policy-Guidance/downloads/SHO-12-002.pdf) (DACA) status were not considered lawfully present for purposes of health coverage eligibility and remained ineligible for these coverage options despite having a deferred action status, which otherwise qualified (https://www.healthcare.gov/immigrants/immigration-status/) for Marketplace coverage. On May 3, 2024, the Biden Administration published new regulations (https://public-inspection.federalregister.gov/2024-09661.pdf) that will change the definition of lawfully present to include DACA recipients for purposes of eligibility to purchase coverage through the ACA Marketplaces and to receive tax credits to help pay for premiums and cost sharing. The rule will become effective on November 1, 2024. Medicaid payments for emergency services may be made on behalf of individuals who are otherwise eligible for Medicaid but for their immigration status. These payments cover costs for emergency care for lawfully present immigrants who remain ineligible for Medicaid as well as for undocumented immigrants.

State Funded Coverage

As of June 2024, 12 states (https://www.kff.org/racial-equity-and-health-policy/issue-brief/state-health-coverage-for-immigrants-and-implications-for-health-coverage-and-care/) **plus D.C. provide comprehensive state-funded coverage for children regardless of immigration status (Figure 5)**. These states include California, Connecticut, Illinois, Maine, Massachusetts, New Jersey, New York, Oregon, Rhode Island, Utah, Vermont, Washington, and D.C. By 2025, Colorado (https://leg.colorado.gov/bills/hb22-1289) and Minnesota (https://www.house.mn.gov/hrd/pubs/mncare.pdf) plan to offer state-funded Medicaid-like coverage to income-eligible children regardless of immigration status. Additionally, two of these states (New Jersey and Vermont) also provide state-funded coverage to income-eligible pregnant people regardless of immigration status, with Vermont extending this coverage for 12 months postpartum.

Figure 5

State-Funded Coverage for Children and Pregnant People Regardless of Immigration Status as of June 2024



Note: In Connecticut, new enrollment of children regardless of immigration status is limited to those under age 13, and to those under age 16 beginning July 2024, but they may stay enrolled up to age 19.

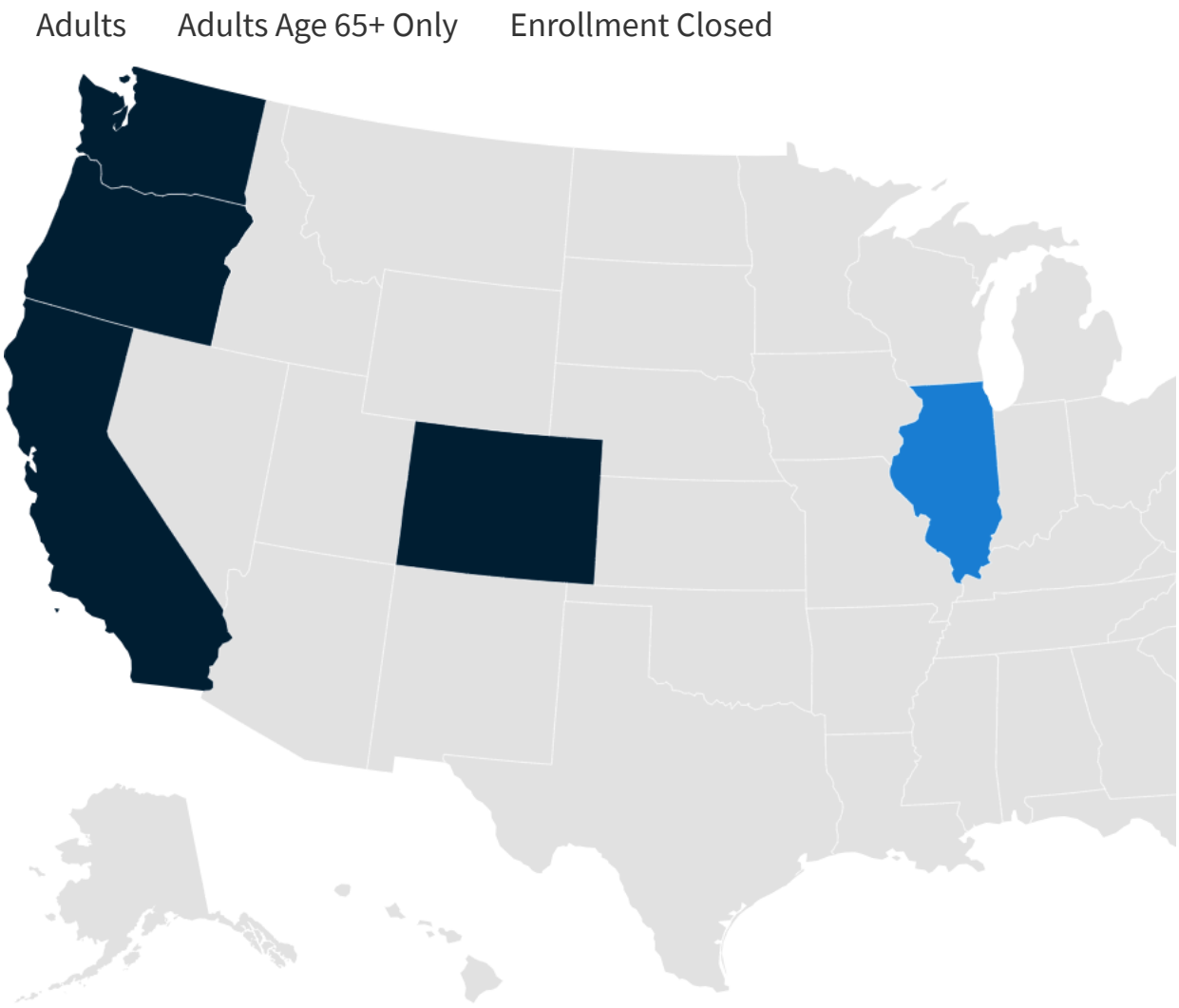
Source: KFF, "A Look at Medicaid and CHIP Eligibility, Enrollment, and Renewal Policies During

As of June 2024, six states (https://www.kff.org/racial-equity-and-health-policy/issue-brief/state-health-coverage-for-immigrants-and-implications-for-health-coverage-and-care/) **(California, Colorado, Illinois, New York, Oregon, Washington) plus D.C. have also expanded fully state-funded coverage to some income-eligible adults regardless of immigration status (Figure 6)**. Some additional states cover (https://files.kff.org/attachment/Table-3-Medicaid-and-CHIP-Eligibility-Enrollment-and-Renewal-Policies-as-States-Prepare-for-the-Unwinding-of-the-Pandemic-Era-Continuous-Enrollment-Provision.pdf) some income-eligible adults who are not otherwise eligible due to immigration status using state-only funds but limit coverage to specific groups, such as

lawfully present immigrants who are in the five-year waiting period for Medicaid coverage, or provide more limited benefits. Maryland and Minnesota have also indicated plans to extend coverage to adults.

Figure 6

State-Funded Coverage for Adults Regardless of Immigration Status as of June 2024



Note: Colorado and Washington provide state marketplace coverage regardless of immigration status. Illinois state-funded coverage for adults and seniors is currently closed. New York state-funded coverage is limited to individuals ages 65 and older.

Source: KFF, "A Look at Medicaid and CHIP Eligibility, Enrollment, and Renewal Policies During the Unwinding of Continuous Enrollment and Beyond", June 2024. • Get the data • Download

Data suggest that state coverage options for immigrants make a difference in their health coverage and health care access and use. The 2023 KFF/LA Times Survey of Immigrants (https://www.kff.org/racial-equity-and-health-policy/poll-finding/kff-la-times-survey-of-immigrants/) shows that immigrants residing in states with more expansive coverage

(https://www.kff.org/racial-equity-and-health-policy/issue-brief/state-health-coverage-for-immigrants-and-implications-for-health-coverage-and-care/) policies for immigrants are less likely to be uninsured compared to their counterparts living in states with less expansive coverage policies. California's 2016 expansion to cover low-income children regardless of immigration status was associated with a 34% (https://www.healthaffairs.org/doi/abs/10.1377/hlthaff.2021.00096?journalCode=hlthaff)decline in uninsurance rates. Similarly, a decline in uninsurance rates. Similarly, a study (https://publications.aap.org/pediatrics/article-abstract/150/3/e2022057034/189211/Insurance-and-Health-Care-Outcomes-in-Regions?autologincheck=redirected?nfToken=00000000-0000-0000-0000-000000000000) found that children who reside in states that have expanded coverage to all children regardless of immigration status were less likely to be uninsured, to forgo medical or dental care, and to go without a preventive health visit than children residing in states that have not expanded coverage. Other research has found that expanding Medicaid coverage to pregnant people regardless of immigration status was associated with higher rates of prenatal care and improved outcomes (https://www.nber.org/system/files/working_papers/w30299/w30299.pdf) including increases in average gestation length and birth weight among newborns, while more restrictive state coverage policies were associated with reduced postpartum care (https://jamanetwork.com/journals/jama/fullarticle/2807288) utilization. The cost of providing insurance to immigrant adults through Medicaid expansion was also found to be less than half (https://www.ncbi.nlm.nih.gov/pmc/articles/PMC10504616/) the per person cost of doing so for U.S-born adults. Recent estimates also suggest that the state-funded expansion to all immigrants regardless of status in California could reduce poverty (https://www.ppic.org/blog/californias-medi-cal-expansion-is-lowering-poverty-among-undocumented-immigrants/) among noncitizen immigrants and their families.

Enrollment Barriers

Among immigrants who are eligible for coverage, many remain uninsured because of a range of enrollment barriers, including fear, confusion about eligibility policies, difficulty navigating the enrollment process, and language and literacy challenges. Research (https://www.kff.org/racial-equity-and-health-policy/issue-brief/living-in-an-immigrant-family-in-america-how-fear-and-toxic-stress-are-affecting-daily-life-well-being-health/) suggests that changes to immigration policy made by the Trump Administration contributed to growing fears among immigrant families about enrolling themselves and/or their children in Medicaid and CHIP even if they were eligible. In particular, changes to the public charge policy (https://www.kff.org/racial-equity-and-health-policy/fact-sheet/public-charge-policies-for-immigrants-implications-for-health-coverage/) likely contributed to decreases in participation in Medicaid among immigrant families and their primarily U.S.-born children. The Biden Administration reversed many of these changes, including the changes to public charge policy, and has increased funding (https://www.kff.org/private-insurance/issue-brief/navigator-funding-restored-in-federal-marketplace-states-for-2022/) for Navigator programs that provide enrollment assistance to individuals, which is particularly important for helping immigrant families enroll in coverage. However, as of 2023, nearly three-quarters (https://www.kff.org/racial-equity-and-health-

policy/issue-brief/health-and-health-care-experiences-of-immigrants-the-2023-kff-la-times-survey-of-immigrants) of immigrant adults, including nine in ten of those who are likely undocumented, report uncertainty or an incorrect understanding about how use of non-cash assistance programs may impact immigration status or incorrectly believe use may reduce the chances of getting a green card in the future. About a quarter (27%) of likely undocumented immigrants and nearly one in ten (8%) lawfully present immigrants say they avoided applying for food, housing, or health care assistance in the past year due to immigration-related fears (https://www.kff.org/racial-equity-and-health-policy/issue-brief/health-and-health-care-experiences-of-immigrants-the-2023-kff-la-times-survey-of-immigrants).

Conclusion

Although the majority of immigrants are working, noncitizen immigrants, particularly those who are likely undocumented, have high uninsured rates due to more limited access to both public and private coverage. Federal legislation (https://www.congress.gov/bill/118th-congress/senate-bill/2646?s=5&r=5) has been proposed that would expand immigrant eligibility for health coverage, though there is no clear path to passage in Congress. In the absence of federal action, some states are filling gaps in access to coverage for immigrants. However, many remain ineligible for any coverage options, contributing to barriers to access and use of care. Those eligible for coverage also face an array of barriers (https://www.urban.org/sites/default/files/2022-11/Immigrant%20Families%20Faced%20Multiple%20Barriers%20to%20Safety%20Net%20Programs%20in%202021.pdf) to enrollment, including fear and confusion about eligibility. The Biden Administration has made changes to public charge (https://www.federalregister.gov/documents/2022/09/09/2022-18867/public-charge-ground-of-inadmissibility) policies that are intended to reduce fears of enrolling in health coverage and accessing care and increased funding for outreach and enrollment assistance, which may help eligible immigrant families enroll and stay enrolled in coverage. However, immigrants continue to have significant confusion around public charge (https://www.kff.org/racial-equity-and-health-policy/issue-brief/health-and-health-care-experiences-of-immigrants-the-2023-kff-la-times-survey-of-immigrants) rules highlighting the importance of outreach and enrollment assistance (https://www.kff.org/private-insurance/issue-brief/navigator-funding-restored-in-federal-marketplace-states-for-2022/), including community-led efforts, to rebuild trust and reduce fears among immigrant families about accessing health coverage and care.

Appendix A: Lawfully Present immigrants by Qualified Status

Qualified Immigrant Categories	Other Lawfully Present Immigrants
• Lawful permanent resident (LPR or green card holder) • Refugee • Asylee • Cuban/Haitian entrant • Paroled into the U.S. for at least one year • Conditional entrant granted before 1980 • Granted withholding of deportation • Battered noncitizen, spouse, child, or parent • Victims of trafficking and his/her spouse, child, sibling, or parent or individuals with pending application for a victim of trafficking visa • Member of a federally recognized Indian tribe or American Indian born in Canada • Citizens of the Marshall Islands, Micronesia, and Palau who are living in one of the U.S. states or territories (referred to as Compact of Free Association or COFA migrants)	• Granted Withholding of Deportation or Withholding of Removal, under the immigration laws or under the Convention against Torture (CAT) • Individual with Non-Immigrant Status, includes worker visas, student visas, U-visa, and other visas, and citizens of Micronesia, the Marshall Islands, and Palau • Temporary Protected Status (TPS) • Deferred Enforced Departure (DED) • Deferred Action Status • Lawful Temporary Resident • Administrative order staying removal issued by the Department of Homeland Security • Resident of American Samoa • Applicants for certain statuses • People with certain statuses who have employment authorization

Endnotes

1. KFF analysis of 2022 American Community Survey (ACS) 1-year Public Use Microdata Sample.

← Return to text (https://www.kff.org/racial-equity-and-health-policy/fact-sheet/key-facts-on-health-coverage-of-immigrants/#endnote_link_597741-1)

2. KFF analysis of 2022 American Community Survey (ACS) 1-year Public Use Microdata Sample.

← Return to text (https://www.kff.org/racial-equity-and-health-policy/fact-sheet/key-facts-on-health-coverage-of-immigrants/#endnote_link_597741-2)

3. KFF/LA Times Survey of Immigrants (April 10 – June 12, 2023).

← Return to text (https://www.kff.org/racial-equity-and-health-policy/fact-sheet/key-facts-on-health-coverage-of-immigrants/#endnote_link_597741-3)

4. Lawfully present immigrants are those who said they are not a U.S. citizen, but currently have a green card (lawful permanent status) or a valid work or student visa; likely undocumented immigrants are those who said they are not a U.S. citizen and do not currently have a green card (lawful permanent status) or a valid work or student visa. These immigrants are classified as “likely undocumented” since they have not affirmatively identified themselves as undocumented.KFF analysis of 2022 American Community Survey (ACS) 1-year Public Use Microdata Sample.

← Return to text (https://www.kff.org/racial-equity-and-health-policy/fact-sheet/key-facts-on-health-coverage-of-immigrants/#endnote_link_597741-4)

5. The estimate of the total number of noncitizens in the US is based on the 2022 American Community Survey (ACS) 1-year Public Use Microdata Sample (PUMS). The ACS data do not directly indicate whether an immigrant is lawfully present or not. We draw on the methods underlying the 2013 analysis by the State Health Access Data Assistance Center (SHADAC) and the recommendations made by Van Hook et. Al. [1](https://www.kff.org/medicaid/issue-brief/the-coverage-gap-uninsured-poor-adults-in-states-that-do-not-expand-medicaid/view/footnotes/#footnote-508802-1), [2](https://www.kff.org/medicaid/issue-brief/the-coverage-gap-uninsured-poor-adults-in-states-that-do-not-expand-medicaid/view/footnotes/#footnote-508802-2) This approach uses the Survey of Income and Program Participation (SIPP) to develop a model that predicts immigration status; it then applies the model to ACS, controlling to state-level estimates of total undocumented population from Pew Research Center. For more detail on the immigration imputation used in this analysis, see the Technical Appendix B (https://www.kff.org/report-section/the-coverage-gap-uninsured-poor-adults-in-states-that-do-not-expand-medicaid-technical-appendix-b-immigration-status-imputation).

← Return to text (https://www.kff.org/racial-equity-and-health-policy/fact-sheet/key-facts-on-health-coverage-of-immigrants/#endnote_link_597741-5)

6. KFF analysis of 2022 American Community Survey (ACS) 1-year Public Use Microdata Sample.

← Return to text (https://www.kff.org/racial-equity-and-health-policy/fact-sheet/key-facts-on-health-coverage-of-immigrants/#endnote_link_597741-6)

7. KFF/LA Times Survey of Immigrants (April 10 – June 12, 2023).

← Return to text (https://www.kff.org/racial-equity-and-health-policy/fact-sheet/key-facts-on-health-coverage-of-immigrants/#endnote_link_597741-7)

8. KFF/LA Times Survey of Immigrants (April 10 – June 12, 2023).

← Return to text (https://www.kff.org/racial-equity-and-health-policy/fact-sheet/key-facts-on-health-coverage-of-immigrants/#endnote_link_597741-8)

9. KFF/LA Times Survey of Immigrants (April 10 – June 12, 2023).

← Return to text (https://www.kff.org/racial-equity-and-health-policy/fact-sheet/key-facts-on-health-coverage-of-immigrants/#endnote_link_597741-9)

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Individual Public Comments Received on Maryland's Section 1332 Waiver Amendment Application August 22, 2024 through September 20, 2024

From: AS
To: CMS StateInnovationWaivers
Subject: 1332 Waiver
Date: Thursday, September 19, 2024

Please approve the waiver. It's the right thing to do!

AS
Bethesda, MD

From: JC
To: CMS StateInnovationWaivers
Subject: Maryland 1332 Waiver for Affordable Care Act, Access to Care
Date: Wednesday, August 28, 2024

Earlier this year, the Maryland State Legislature authorized the Maryland Health Benefit Exchange to seek a Section 1332 State Innovation Waiver of the Affordable Care Act to allow Maryland to offer access to the Exchange to eligible undocumented immigrants to obtain health insurance coverage.

There are about 250,000 undocumented immigrants in Maryland who may be eligible for access to the Exchange which they must pay for. They work, contribute to the local economies and having access to health care will reduce the over reliance on emergency room care, provide preventative health care and provide a more robust and secure public health environment.

I encourage CMS to approve Maryland's requested waiver.
Thank you.

JC
Ellicott City, MD

From: MC
To: CMS StateInnovationWaivers
Subject: Maryland"s Access to Care Act
Date: Wednesday, August 28, 2024

As you are aware, earlier this year the Maryland State Legislature authorized the Maryland Health Benefit Exchange to seek a Section 1332 State Innovation Waiver of the Affordable Care Act to allow Maryland to offer access to the Exchange to eligible undocumented immigrants to obtain health insurance coverage.

There are about 250,000 undocumented immigrants in Maryland who may be eligible for access to the Exchange which they must pay for. I worked with people in this population for 15 years. They work and contribute to the local economies, and having access to health care will reduce the over reliance on emergency room care, provide preventative health care and provide a more robust and secure public health environment for all Maryland communities.

I therefore wholeheartedly encourage CMS to approve Maryland's requested waiver.

MC
Baltimore, MD