Whereas, our American Medical Association has numerous policies calling for adequate federal reimbursement for care for undocumented immigrants; and

Whereas, our AMA specifically supports Medicaid coverage for undocumented immigrants for scheduled, outpatient, non-emergency maintenance dialysis and for healthcare during pregnancy and up to 12 months postpartum; and

Whereas, our AMA “supports extending eligibility to purchase Affordable Care Act (ACA) marketplace coverage to undocumented immigrants and Deferred Action for Childhood Arrivals (DACA) recipients” and “recognizes the potential for state and local initiatives to provide coverage to immigrants without regard to immigration status”; and

Whereas, in June 2023, our AMA wrote a letter to the Centers for Medicare and Medicaid Services (CMS) supporting proposed regulations to extend Medicaid, Children’s Health Insurance Program (CHIP), and ACA plans to Deferred Action for Childhood Arrivals (DACA) participants and also expressing to CMS our stance on ACA coverage for undocumented immigrants1; and

Whereas, in the US, only documented adults and children (permanent residents, current visa holders, and those with active refugee, asylum, trafficking, or another qualified or protected status) are eligible for Medicaid and CHIP2; and

Whereas, undocumented immigrants are ineligible for Medicaid and CHIP aside from emergency coverage and therefore only receive insurance through their employer, through their educational institution if they are a student, or if purchased out-of-pocket2; and

Whereas, 11 million undocumented immigrants (including 650,000 DACA participants) reside in the US, and over 5 million (nearly half) live in California, New York, and Texas3; and

Whereas, 5 million undocumented immigrants (nearly half) are completely uninsured, 2 to 3 times the uninsured rate among documented immigrants, 4 times the uninsured rate among citizens, and 20% of the entire US uninsured population4; and

Whereas, about 20% of undocumented adults and over 30% of undocumented children live in poverty, with a median household income of $36,000, or 120% of the Federal Poverty Level (FPL) threshold for a household of four5,−6; and

Whereas, 5 million undocumented immigrants (nearly half) are completely uninsured, 2 to 3 times the uninsured rate among documented immigrants, 4 times the uninsured rate among citizens, and 20% of the entire US uninsured population4; and

Whereas, about 20% of undocumented adults and over 30% of undocumented children live in poverty, with a median household income of $36,000, or 120% of the Federal Poverty Level (FPL) threshold for a household of four5,−6; and
Whereas, the median undocumented household income of 120% FPL is below the 138% FPL threshold for Medicaid eligibility in expansion states and well below the national average threshold for CHIP at 255% FPL; and

Whereas, in addition to ethical considerations for coverage, fiscal concerns are alleviated by consistent data demonstrating that undocumented immigrants pay billions in federal and state taxes annually while receiving no public benefits in return, and if given some federal status, contributions to federal public funds would only increase; and

Whereas, undocumented immigrants are and will continue to be a long-term part of American society, as the average individual has resided in the US for 15 years; and

Whereas, while undocumented immigrants can sometimes access outpatient primary care at public and charity clinics, access to specialty or hospital care is greatly limited; and

Whereas, while all hospitals are required to screen and stabilize undocumented immigrants in emergency departments, much of this care is costlier than necessary due to lack of earlier treatment and may then go uncompensated, and require being offset by public funds anyway, which could instead fund comprehensive outpatient coverage from the start; and

Whereas, California, one of the states with the largest undocumented population, expanded Medicaid and CHIP to all otherwise eligible undocumented immigrants; and

Whereas, New York, one of the states with the largest undocumented population, expanded Medicaid to DACA participants and CHIP to undocumented children; and

Whereas, expansion of Medicaid and CHIP to undocumented immigrants would significantly reduce the uninsured rate, increase reimbursement for physicians and hospitals providing uncompensated care, and avoid cost and resource burdens to the health system by promoting preventive, chronic, outpatient care over emergency and inpatient care; therefore be it

RESOLVED, that our American Medical Association advocate for the removal of eligibility criteria based on immigration status from Medicaid and CHIP. (Directive to Take Action)

Fiscal Note: Modest - between $1,000 - $5,000

Received: 09/27/2023

REFERENCES
RELEVANT AMA POLICY

H-160.956 Federal Funding for Safety Net Care for Undocumented Aliens
Our AMA will lobby Congress to adequately appropriate and disperse funds for the current programs that provide reimbursement for the health care of undocumented aliens. [Sub. Res. 207, A-93; Reaffirmed BOT Rep. 17 - I-94; Reaffirmed by Ref. Cmt. B, A-96; Reaffirmation A-02; Reaffirmation A-07; Reaffirmed: BOT Rep. 22, A-17; Reaffirmation: A-19; Reaffirmation: I-19]

D-440.985 Health Care Payment for Undocumented Persons
Our AMA shall assist states on the issue of the lack of reimbursement for care given to undocumented immigrants in an attempt to solve this problem on a national level. [Res. 148, A-02; Reaffirmation A-07; Reaffirmed: CMS Rep. 01, A-17; Reaffirmation: A-19; Reaffirmation: I-19]

H-130.967 Action Regarding Illegal Aliens
Our AMA supports the legislative and regulatory changes that would require the federal government to provide reasonable payment for federally mandated medical screening examinations and further examination and treatment needed to stabilize a condition in patients presenting to hospital emergency departments, when payment from other public or private sources is not available. [BOT Rep. MM, A-89; Reaffirmed by BOT Rep. 17 - I-94; Reaffirmed by Ref. Cmt. B, A-96; Reaffirmation A-02; Reaffirmation A-07; Reaffirmed: BOT Rep. 22, A-17]

H-290.957 Medicaid Dialysis Policy for Undocumented Patients
Our AMA will work with the Centers for Medicare and Medicaid Services and state Medicaid programs to cover scheduled outpatient maintenance dialysis for undocumented patients with end stage kidney disease under Emergency Medicaid. [Res. 121, A-21]

D-290.974 Extending Medicaid Coverage for One Year Postpartum
Our AMA will work with relevant stakeholders to: (1) support and advocate, at the state and federal levels, for extension of Medicaid and Children’s Health Insurance Program (CHIP) coverage to at least 12 months after the end of pregnancy; and (2) expand Medicaid and CHIP eligibility for pregnant and postpartum non-citizen immigrants. [Res. 221, A-19; Modified: Joint CMS/CSAPH Rep. 1, I-21; Modified: Res. 701, I-21]

H-165.823 Options to Maximize Coverage under the AMA Proposal for Reform
1. That our AMA advocate for a pluralistic health care system, which may include a public option, that focuses on increasing equity and access, is cost-conscious, and reduces burden on physicians.
2. Our AMA will advocate that any public option to expand health insurance coverage must meet the following standards:
   a. The primary goals of establishing a public option are to maximize patient choice of health plan and maximize health plan marketplace competition.
   b. Eligibility for premium tax credit and cost-sharing assistance to purchase the public option is restricted to individuals without access to affordable employer-sponsored coverage that meets standards for minimum value of benefits.
c. Physician payments under the public option are established through meaningful negotiations and contracts. Physician payments under the public option must be higher than prevailing Medicare rates and at rates sufficient to sustain the costs of medical practice.
d. Physicians have the freedom to choose whether to participate in the public option. Public option proposals should not require provider participation and/or tie physician participation in Medicare, Medicaid and/or any commercial product to participation in the public option.
e. The public option is financially self-sustaining and has uniform solvency requirements.
f. The public option does not receive advantageous government subsidies in comparison to those provided to other health plans.
g. The public option shall be made available to uninsured individuals who fall into the “coverage gap” in states that do not expand Medicaid—having incomes above Medicaid eligibility limits but below the federal poverty level, which is the lower limit for premium tax credits—at no or nominal cost.

3. Our AMA supports states and/or the federal government pursuing auto-enrollment in health insurance coverage that meets the following standards:
a. Individuals must provide consent to the applicable state and/or federal entities to share their health insurance status and tax data with the entity with the authority to make coverage determinations.
b. Individuals should only be auto-enrolled in health insurance coverage if they are eligible for coverage options that would be of no cost to them after the application of any subsidies. Candidates for auto-enrollment would, therefore, include individuals eligible for Medicaid/Children’s Health Insurance Program (CHIP) or zero-premium marketplace coverage.
c. Individuals should have the opportunity to opt out from health insurance coverage into which they are auto-enrolled.
d. Individuals should not be penalized if they are auto-enrolled into coverage for which they are not eligible or remain uninsured despite believing they were enrolled in health insurance coverage via auto-enrollment.
e. Individuals eligible for zero-premium marketplace coverage should be randomly assigned among the zero-premium plans with the highest actuarial values.
f. Health plans should be incentivized to offer pre-deductible coverage including physician services in their bronze and silver plans, to maximize the value of zero-premium plans to plan enrollees.
g. Individuals enrolled in a zero-premium bronze plan who are eligible for cost-sharing reductions should be notified of the cost-sharing advantages of enrolling in silver plans.
h. There should be targeted outreach and streamlined enrollment mechanisms promoting health insurance enrollment, which could include raising awareness of the availability of premium tax credits and cost-sharing reductions, and establishing a special enrollment period.

4. Our AMA: (a) will advocate that any federal approach to cover uninsured individuals who fall into the “coverage gap” in states that do not expand Medicaid—having incomes above Medicaid eligibility limits but below the federal poverty level, which is the lower limit for premium tax credit eligibility—make health insurance coverage available to uninsured individuals who fall into the coverage gap at no or nominal cost, with significant cost-sharing protections; (b) will advocate that any federal approach to cover uninsured individuals who fall into the coverage gap provide states that have already implemented Medicaid expansions with additional incentives to maintain their expansions; (c) supports extending eligibility to purchase Affordable Care Act (ACA) marketplace coverage to undocumented immigrants and Deferred Action for Childhood Arrivals (DACA) recipients, with the guarantee that health plans and ACA marketplaces will not collect and/or report data regarding enrollee immigration status; and (d) recognizes the potential for state and local initiatives to provide coverage to immigrants without regard to immigration status. [CMS Rep. 1, I-20; Appended: CMS Rep. 3, I-21; Reaffirmation: A-22; Reaffirmed: CMS Rep. 3, A-22; Reaffirmed: Res. 122, A-22; Modified: Res. 813, I-22]