

# Expanding Insurance Coverage to Undocumented Immigrants in Connecticut

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## About This Report

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Policymakers in Connecticut are considering various options to improve insurance coverage among undocumented immigrants in the state. In particular, they are considering allowing undocumented immigrants, as well as legally present recent immigrants who have been in the United States for less than five years, to enroll in Medicaid if they are otherwise eligible. They are also considering allowing undocumented immigrants to enroll in marketplace coverage and receive subsidies. In both cases, these expansions would be funded entirely by the state. In this report, we use the RAND Corporation's COMPARE microsimulation model to estimate the impacts of such policy options. For each policy scenario, we estimate enrollment, premiums, state spending, and hospital spending on uncompensated care. We also provide a demographic profile of the newly insured population and the immigrant population that remains uninsured.

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# Summary

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## Background

There are roughly 113,000 undocumented immigrants living in the state of Connecticut, and almost 60 percent of this population lacks access to health insurance (Migration Policy Institute, undated-a). Although the Affordable Care Act (ACA) greatly expanded access to health insurance coverage in the United States, the undocumented population—excluded from these reforms—represents a disproportionate share of the uninsured population nationwide (Kaiser Family Foundation [KFF], 2021). In particular, undocumented immigrants are not eligible for Medicaid and cannot enroll in marketplace coverage or receive marketplace subsidies. Legally present immigrants are also at high risk for being uninsured (KFF, 2021), and legally present recent immigrants are ineligible for Medicaid until they have been legally present in the country for five years.

Policymakers in Connecticut are considering removing immigration status requirements from Medicaid and Children’s Health Insurance Program (CHIP) eligibility, enabling both undocumented and legally present recent immigrants to enroll in these programs. The state would fully fund this expansion, with no federal matching. In addition, the state is considering a look-alike individual market plan, to be offered off-marketplace, that would allow undocumented immigrants to purchase coverage and receive state-funded advance premium tax credits (APTCs) and cost-sharing reductions (CSRs). State-funded APTCs on the look-alike plan would be available to people with incomes between 138 and 400 percent of the federal poverty level (FPL) with no other affordable source of insurance. State-funded CSRs on the look-alike plan would be available to people with incomes between 138 and 250 percent of FPL, but—unlike on the marketplace—the cost of these CSRs would not be loaded onto the silver plan.<sup>1</sup> As with CSRs available to legally present Connecticut residents, CSRs on the look-alike plan would be enhanced via Covered Connecticut, a 2020 state law that used state funding to enhance CSR amounts for residents with incomes below 175 percent of FPL. These reforms would build on 2021 state legislation that expanded Medicaid to undocumented immigrants who are pregnant or children through the age of eight years (Connecticut General Assembly, 2021a) and prior legislation that expanded Medicaid eligibility to legally present recent immigrants who are pregnant or through the age of 20 (Division of Medicaid and Children’s Health Operations, Boston Regional Office, 2014).

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<sup>1</sup> In 2017, the Trump administration halted federal payments of CSRs, and most states, including Connecticut, responded by allowing insurers to load the costs of CSRs onto *silver marketplace plans* (i.e., plans with 70-percent actuarial value, which are used to set the benchmark for determining federal APTC funding).

In this report, we use a microsimulation modeling approach to analyze the effects of such policies on health insurance enrollment and state spending in Connecticut. We consider three specific policy scenarios, driven by policy changes under consideration in the state. The specifics of each policy scenario are shown in Table S.1. In Scenario 1, Medicaid eligibility is further expanded to the full population of otherwise-eligible undocumented and legally present recent immigrants. Scenarios 2 and 3 additionally expand marketplace subsidy eligibility to undocumented immigrants, with two different levels of income eligibility.

**Table S.1. Policy Scenarios Considered**

Policy Scenario	Medicaid/CHIP Eligibility		Individual Market Subsidy Eligibility	
	Undocumented Immigrants	Legally Present Recent Immigrants (< 5 Years)	Undocumented Immigrants	Legally Present Recent Immigrants (< 5 Years)
Current Law	Eligible if pregnant or child up to age 8, subject to income limits <sup>a</sup>	Eligible if pregnant or child/young adult up to age 20, subject to income limits <sup>a</sup>	Not eligible	Eligible if income ≤ 400% FPL <sup>b</sup> and have no other affordable coverage option
Scenario 1	Eligible subject to income limits <sup>a</sup>	Eligible subject to income limits <sup>a</sup>	Not eligible	Eligible if income ≤ 400% FPL <sup>b</sup> and not Medicaid/CHIP eligible or otherwise have an affordable coverage option
Scenario 2	Eligible subject to income limits <sup>a</sup>	Eligible subject to income limits <sup>a</sup>	Eligible if income ≤ 200% FPL and not Medicaid/CHIP eligible or otherwise have an affordable coverage option	Eligible if income ≤ 400% FPL <sup>b</sup> and not Medicaid/CHIP eligible or otherwise have an affordable coverage option
Scenario 3	Eligible subject to income limits <sup>a</sup>	Eligible subject to income limits <sup>a</sup>	Eligible if income ≤ 400% FPL and not Medicaid/CHIP eligible or otherwise have an affordable coverage option	Eligible if income ≤ 400% FPL <sup>b</sup> and not Medicaid/CHIP eligible or otherwise have an affordable coverage option

<sup>a</sup> Income limits for Medicaid are as follows: up to 138 percent of FPL for childless adults, up to 160 percent of FPL for parents, up to 263 percent of FPL for pregnant persons, and up to 323 percent FPL for children aged 0 to 18 years.

<sup>b</sup> The main analyses assume that (1) the extensions to individual market subsidy eligibility to individuals with incomes of more than 400 percent of FPL that were part of the American Rescue Plan Act of 2021 will expire at the end of 2022, and (2) as a result, only individuals with incomes of less than 400 percent of FPL would be eligible for the individual market subsidy.

We also consider any unintended effects for U.S. citizens and legally present immigrants who have resided in the United States for more than five years.

## Methods

We developed a Connecticut-specific version of the COMPARE microsimulation model (Cordova et al., 2013) to estimate how undocumented immigrants and legally present recent immigrants would respond to new health insurance enrollment options. Using COMPARE, we created a representation of the Connecticut population by reweighting national-level data to resemble Connecticut in terms of key demographic characteristics (e.g., age, income, race, and ethnicity). Modeled individuals then choose among various health insurance enrollment options by comparing their costs and benefits.

Because it is not reported in most data sources, we imputed immigration documentation status using logic that was informed by algorithms used in the literature (Van Hook et al., 2021; Passel and Cohn, 2018) that prioritized noncitizens and ruled out individuals who reported having jobs that are typically unavailable to undocumented immigrants (e.g., police officer) or if they reported benefits that are unavailable to the undocumented population, such as Social Security income.

A key challenge for this analysis was determining what share of undocumented immigrants would be likely to take up insurance coverage if it were available to them. Literature suggests that take-up would be lower among the undocumented population than among the legally present recent immigrant population because of such factors as information barriers and hesitancy to present to a government agency (Whitener, 2020). However, because few states have expanded coverage to their undocumented populations and because the denominator is uncertain, estimates of take-up rates are highly uncertain. There is similar uncertainty in estimating how much health care undocumented populations will use once they become insured. To address these uncertainties, we conducted sensitivity analyses that varied both the take-up and utilization rates.

## Results

Figure S.1 shows the estimated insurance enrollment of undocumented and legally present recent immigrants in the coverage expansion scenarios relative to current law. We estimate that enabling undocumented and legally present recent immigrant populations to enroll in Medicaid will increase total insurance enrollment among this population by approximately 21,400 individuals, or 43 percent (Scenario 1 relative to current law). In sensitivity analyses, we found that the change in enrollment ranged from 17,500 to 25,100 people (in Scenario 1), depending on assumptions about the take-up rate. The number of individuals enrolling in Medicaid (28,900) exceeds the total increase in insurance enrollment because some people move to Medicaid from other sources of coverage. In particular, individuals move from employer-sponsored insurance (ESI) and unsubsidized individual market coverage into Medicaid as undocumented and legally present recent immigrants gain Medicaid eligibility. Allowing undocumented populations to access subsidies in the individual health insurance market leads to a small increase over the

Medicaid-only scenario, adding 2,200 to 3,000 additional enrollees (Scenarios 2 and 3, respectively).

**Figure S.1. Estimated Insurance Enrollment Among Undocumented and Legally Present Recent Immigrants in Connecticut, 2022**

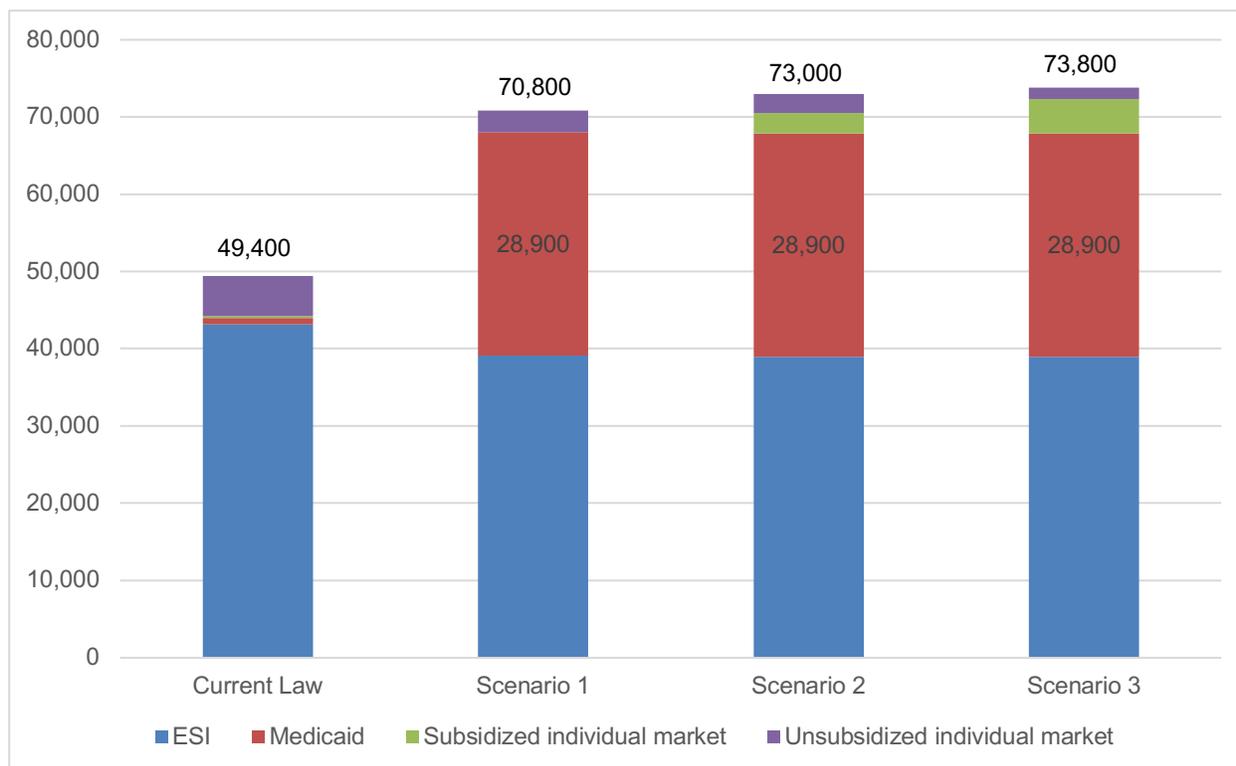
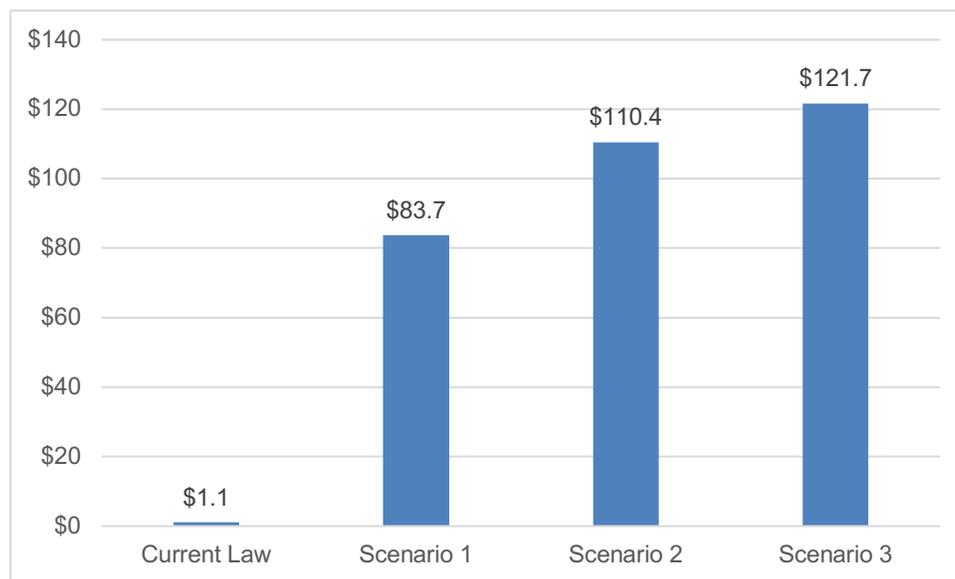


Figure S.2 shows the estimated cost to Connecticut for 2023 from enacting these policies. We estimate that spending will increase by nearly \$83 million in Scenario 1, which expands only Medicaid. In sensitivity analyses, we found that this estimate could range from \$70 to \$93 million, depending on assumptions about take-up rate and health care spending, although even these estimates carry a high degree of uncertainty. Scenarios 2 and 3, which expand marketplace subsidies to undocumented immigrants, have a relatively small effect on coverage while having a larger effect on costs (Scenarios 2 and 3), which increase by 32 to 45 percent over the Medicaid-only scenario.

Our microsimulation analysis focuses only on the costs of providing Medicaid and marketplace subsidies and does not directly consider potential savings to hospitals from reduced uncompensated care spending or potential savings to the state from reduced spending on emergency Medicaid services or recouped federal APTC spending. However, we provide a high-level estimate of potential savings to hospitals from reduced spending on uncompensated care, which could amount to roughly \$63 million in Scenario 1 to \$72 million in Scenario 3. In

addition, high-level data provided by the state suggest that the state spent approximately \$15 million on emergency Medicaid services in 2021.

**Figure S.2. Estimated Cost to Connecticut for Coverage of Undocumented and Legally Present Recent Immigrants, 2023 (\$ millions)**



NOTE: Costs include new state spending on Medicaid and marketplace subsidies (APTCs and CSRs). We do not account for the costs of reduced spending on emergency Medicaid services.

We estimate that these policies would have minimal effects on enrollment and premiums for U.S. citizens and legally present residents who have lived in the United States for five or more years.

## Discussion

We estimate that expanding Medicaid and individual market subsidy eligibility to otherwise-eligible undocumented and legally present recent immigrants would lead to an increase in coverage among this population by 21,000 to 24,000 individuals and some movement from ESI and unsubsidized individual market coverage into the new health insurance options. These changes did not substantially impact total insurance coverage among U.S. citizens and other immigrants residing in Connecticut. Allowing undocumented immigrants to receive individual market subsidies (in addition to expanding Medicaid eligibility) had only a minor impact on total insurance enrollment among this population, although it would substantially improve affordability of coverage. In turn, changes in individual market premiums were negligible. We estimate costs to the state to extend Medicaid coverage to undocumented and legally present recent immigrants would be approximately \$83 million. On top of the costs to extend Medicaid coverage to individuals who are currently ineligible because of their immigration status, the cost

to Connecticut to expand individual market subsidies to undocumented immigrants with incomes less than 200 percent of FPL would be \$27 million, while expanding subsidies to undocumented immigrants with incomes less than 400 percent of FPL would cost the state \$38 million. Because the federal government would not fund these programs, we assumed that the costs of these insurance-eligibility expansions would be borne entirely by the state.

In each scenario, almost one-quarter of undocumented and legally present recent immigrants newly insured by Medicaid or receiving subsidies on the individual market were previously insured via ESI or unsubsidized individual market coverage. As a result, the state will absorb costs for some individuals who would have been insured without the policy change. However, these policies would also substantially increase the affordability of health care coverage for this population, particularly for individuals who qualify for Medicaid.

Another consideration for policymakers is the potential cost savings from such policy options. These could stem from (1) cost savings to hospitals on uncompensated care spending, and (2) direct savings to the state that we did not estimate in our analysis. For example, Connecticut currently has an emergency Medicaid program that covers emergency care to individuals who qualify based on income, regardless of immigration status. The costs for this program (approximately \$15 million in 2021) would presumably be substantially reduced by the decrease in uninsurance among undocumented and legally present recent immigrants. Furthermore, by offering Medicaid to legally present recent immigrants, the state would forego federal APTC funding for the portion of this population that would have otherwise enrolled in marketplace coverage and been eligible for subsidies. Therefore, it is possible that Connecticut could recoup some of the forgone APTC funding via a Section 1332 waiver.

There are several limitations associated with this analysis that are important to note. In particular, there is uncertainty around the size and demographics of the undocumented population, the Medicaid take-up rate, and expected health care spending among undocumented immigrants. However, we conducted sensitivity analyses around the take-up rate and health care spending assumptions that we used in the model, and they had relatively small impacts on the overall findings, in the expected directions.

This analysis suggests that removing immigration status requirements for Medicaid and individual market subsidy eligibility would decrease uninsurance among the undocumented and legally present recent immigrant populations by 32 to 37 percent. Costs to the state would range from \$83 to \$121 million (or approximately \$3,900 to \$4,900 per newly insured individual), without factoring in savings to hospitals on uncompensated care or any costs that the state could recoup from forgone federal APTC payments. Overall, expanding Medicaid and individual market subsidy eligibility to individuals who would qualify were it not for their immigration status has promise to improve insurance coverage and affordability in Connecticut for undocumented and legally present recent immigrant populations, while not substantially impacting legal residents.

# 1. Introduction

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The Affordable Care Act (ACA) greatly increased health insurance coverage in the United States through a number of policy changes, including Medicaid expansion and the introduction of state-based health insurance marketplaces, for which premium and cost-sharing subsidies are available to low-income enrollees. However, a key population left out of these reforms is undocumented immigrants.

In 2019, while slightly less than 10 percent of U.S. citizens were uninsured, nearly 50 percent of undocumented immigrants were uninsured (Kaiser Family Foundation [KFF], 2021). Undocumented immigrants are not only ineligible for health insurance coverage provided by the federal government, such as Medicare, but also are ineligible for insurance through the health insurance marketplaces established by the ACA. However, even though they are generally ineligible for Medicaid, states can choose to expand Medicaid coverage to undocumented immigrants by using state funds (Salami, 2017). Currently, only six states and the District of Columbia offer Medicaid coverage to some portion of their populations who are otherwise ineligible because of their immigration status (Community Catalyst, 2021). Therefore, in most states, undocumented immigrants are eligible only for employer-sponsored insurance (ESI) and off-marketplace individual market plans. However, undocumented immigrants are less likely to hold jobs that offer ESI and more likely to be considered low income than other U.S. residents (KFF, 2021). This makes it more challenging for undocumented immigrants to afford off-marketplace individual market plans, for which subsidies are not available.

Some legally present recent immigrants also face similar barriers to health insurance coverage. In particular, there is a five-year eligibility waiting period for legally present nonpregnant adult immigrants to qualify for Medicaid or other public health insurance options. Unlike undocumented immigrants, they are allowed to purchase coverage and receive subsidies via the health insurance marketplaces. Throughout this report, we use the term *legally present recent immigrants* to refer to the population of legally present immigrants who have lived in the United States for fewer than five years.

The state of Connecticut is considering implementing two policies that would expand access to health insurance to immigrant populations who are currently ineligible:

- Removing immigration status requirements from Connecticut’s Medicaid program eligibility requirements for HUSKY A (traditional Medicaid population), HUSKY B (Children’s Health Insurance Program [CHIP] population), and HUSKY D (Medicaid expansion population)<sup>2</sup>

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<sup>2</sup> Currently, nonpregnant undocumented immigrants who are over the age of eight years and nonpregnant legally present recent immigrants over the age of 20 are not eligible for Medicaid.

- Creating a look-alike individual market plan to be offered off-marketplace that would allow undocumented immigrants to purchase coverage and receive state-funded subsidies if qualified by income.<sup>3</sup>

Both of these policies would be funded entirely by the state.

To analyze the potential impact of the above proposals, we used a microsimulation approach to estimate enrollment, premiums, state spending, and hospital spending on uncompensated care, as well as to provide a demographic profile of the newly insured population and of the immigrant population that would remain uninsured. These proposals would build upon already passed Connecticut legislation that will expand Medicaid coverage regardless of immigration status to children aged 8 and under, as well as pregnant persons, who qualify for Medicaid based on income (Connecticut General Assembly, 2021a). We consulted with state policymakers to develop policy scenarios for simulation that were most relevant to the proposals that the state is currently pursuing or considering pursuing. In particular, we assessed the impact of the following policy scenarios:

- Current law: Medicaid<sup>4</sup> available to pregnant persons and children aged 0 to 8 years who would qualify but for their immigration status
- Scenario 1: Medicaid available to all individuals who would qualify but for their immigration status
- Scenario 2: Medicaid available to all individuals who would qualify but for their immigration status; individual market subsidies available to individuals who would qualify but for their immigration status with incomes less than 201 percent of the federal poverty level (FPL)
- Scenario 3: Medicaid and individual market subsidies available to all individuals who would qualify but for their immigration status.

The scenarios that expand individual market subsidy eligibility to undocumented immigrants would use state funding to extend the following existing federal and state policies to this population:

- *federal advance premium tax credits (APTCs)*. Federal APTCs are available to individuals with incomes between 100 and 400 percent of FPL who do not have another affordable coverage option. Prior to 2021, the ACA APTC structure capped premium spending at 2.07 to 9.83 percent of income for the benchmark silver plan.

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<sup>3</sup> We base this policy option on legislation put forth in 2020 by the state of Colorado (the only other state that has recently advanced plans to extend individual market subsidies to undocumented immigrants), which would create state-subsidized individual health insurance plans for low-income individuals who do not qualify for federal subsidies (Colorado General Assembly, 2020).

For families whose members have different immigration status (i.e., *mixed immigration status*), we assumed that the legal residents would continue to enroll in on-marketplace plans, while the undocumented residents would enroll in the off-marketplace plan. The state would adjust the subsidy amount such that the family would pay no more out-of-pocket (OOP) than if they were all enrolled on- (or off-) marketplace.

<sup>4</sup> Note that we use the term *Medicaid* generically in this report to refer to both Medicaid and CHIP.

- the *revised federal APTC structure due to the American Rescue Plan Act of 2021 (ARP)* (McDermott, Cox, and Amin, 2021), which is currently set to expire at the end of 2022,
  - extends APTCs to individuals with incomes over 400 percent of FPL, with a cap on premium spending of 8.5 percent of income for the benchmark silver plan
  - enhances APTCs for the population that was already eligible (100–400 percent of FPL), with premium spending caps reduced to 0 to 8.5 percent of income for the benchmark silver plan.
- the *federal cost-sharing reduction (CSR) subsidy structure*. CSRs are made available to APTC-eligible marketplace enrollees who have incomes between 100 and 250 percent of FPL and are enrolled in a silver plan. In 2017, the Trump administration halted federal payments of CSRs, and most states, including Connecticut, responded by allowing insurers to load the costs of CSRs onto silver marketplace plans, thereby increasing the benchmark premium. In turn, the higher premium increases APTCs, giving consumers more purchasing power. The state-funded CSRs that would be made available to undocumented immigrants off-marketplace would be funded directly by the state and, therefore, not loaded onto the cost of silver plans.
- *Covered Connecticut*. Passed in 2021, Covered Connecticut uses state funding to enhance APTCs and CSRs for marketplace enrollees who are eligible for subsidies and have incomes of up to 175 percent of FPL, such that they pay nothing in premiums for the benchmark plan and in CSRs. The state-funded portion of CSRs are paid directly by the state rather than loaded onto the cost of the silver plan.

To estimate the insurance enrollment, premiums, and costs to the state that would occur as a result of the above scenarios, we used the RAND Corporation’s COMPARE microsimulation model (Cordova et al., 2013), customized to represent the state of Connecticut. Our analyses build on prior work by members of this project team to describe in detail the status of health insurance enrollment among the under-65 population in Connecticut and to provide breakdowns of insurance enrollment by age and ethnicity (Rao, Girosi, and Eibner, 2021).

## 2. Policy Landscape

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The impact of health insurance on access to health care, health outcomes, and financial outcomes is well documented. Individuals who lack insurance are more likely to postpone or forgo health care services and to report not having a usual source of care (Garfield, Orgera, and Damico, 2019). Uninsured individuals who report being in good health are less likely to remain in good health compared with insured people; the effect of not having health insurance increases over time (Barker and Li, 2020), generally leading uninsured individuals to have worse health outcomes (Garfield, Orgera, and Damico, 2019). Thus, the odds of mortality are higher among the uninsured than among the insured (Woolhandler and Himmelstein, 2017; Gelatt, 2016). Beyond health care access and health outcomes, health insurance also plays an important role in financial well-being: Medicaid expansions have been found to significantly reduce the number of unpaid bills and the amount of debt sent to collection agencies (Hu et al., 2016). There are particular nuances to the impacts of health insurance on mixed-immigration status families. For example, mixed-status families are less likely to seek health care services or coverage for U.S. citizen children, particularly in families with siblings of different immigration status (Castañeda and Melo, 2014).

Six states have enacted measures to extend insurance coverage to undocumented and legally present recent immigrants. The primary means for these extensions has generally been by removing immigration status restrictions from Medicaid eligibility, at least for some portions of the population. Specifically, California, Illinois, Massachusetts, New York, Oregon, Washington, and the District of Columbia have expanded Medicaid coverage (or Medicaid-like coverage) to children (up to the age of 18 years) and pregnant persons who qualify based on income, regardless of their immigration status (Community Catalyst, 2021). California and Illinois have further expanded full-scope Medicaid coverage to portions of the adult population, and the District of Columbia has extended limited-scope medical benefits of its Medicaid-like program to all adults with qualifying incomes (Manatt Health, 2021). A handful of additional states will move forward with Medicaid coverage for children in 2022 and beyond. Without these state-funded options, undocumented immigrants who cannot afford to purchase private insurance largely go uninsured.

Another option that a small number of states have considered is to use state funding to provide subsidies for undocumented immigrants who wish to enroll in individual market coverage. This option presents some legal complexity, because federal law prohibits undocumented immigrants (though not legally present recent immigrants) from enrolling in on-marketplace coverage. In 2016, California put forth legislation that would have allowed the state to submit a federal waiver request to this rule, under the argument that it would be revenue-neutral to the federal government. However, the state later withdrew their request following the

2016 presidential election (Ibarra and Terhune, 2017). More recently, in 2021, Colorado passed legislation that will create the Colorado Option, a public option plan that would be offered with the same benefits both on- and off-marketplace (Colorado Department of Regulatory Agencies, 2021). Undocumented immigrants would be permitted to purchase coverage on the off-marketplace version of the plan and to receive state-funded subsidies.

### 3. Methodology

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We used the RAND COMPARE microsimulation model to estimate health insurance enrollment, premiums, and costs to the state under current law and three policy option scenarios. In addition to these outcomes, we examined the characteristics of the newly insured population and the population that would remain uninsured under each scenario. COMPARE is a microsimulation model that uses nationally representative data and economic theory to analyze the effects of health policy changes. In the model, individuals and households choose insurance coverage based on the costs and benefits of available plans, and employers decide whether to offer insurance to their employees. The primary data sources in the model are the 2020 Current Population Survey (CPS), the 2019 Medical Expenditures Panel Survey (MEPS), and the 2019 KFF Employer Health Benefit Survey. We regularly update the model to reflect population growth, health care cost growth, and policy changes. We describe the details of the COMPARE model in Appendix A.

For these analyses, we created a Connecticut-specific version of COMPARE with modifications that we describe in the following sections. COMPARE does not include two key variables that are required for this analysis: immigration status and pregnancy status; we therefore imputed these variables. Because COMPARE is nationally representative, we reweighted the model to be representative of Connecticut in 2019, using health insurance enrollment estimates by age, gender, race, and ethnicity.

#### Imputation of Immigration and Pregnancy Status

For the purposes of these analyses, we imputed immigration and pregnancy status of individuals because this status, in part, determines Medicaid eligibility.

##### *Immigration Status*

To impute undocumented immigrant status, we used a methodology informed by algorithms that other researchers have used to determine immigration status in publicly available data (Van Hook et al., 2021; Passel and Cohn, 2018). The algorithm is executed in a few steps. We started with the entire population in the CPS data and ran that data through a series of exclusion criteria to rule out the possibility that an individual is an undocumented immigrant. In particular, we assumed that individuals in the CPS data who reported being a U.S. citizen, having public health insurance coverage or subsidized marketplace coverage; being a government employee or having another occupation that requires U.S. citizenship, such as a police officer; or having received any social program benefits, such as Supplemental Security Income, food stamps, or Social Security, were not undocumented immigrants. After running CPS data through all the exclusion criteria, we applied further restrictions, based on family structure, to our pool of candidates. In particular,

we did not allow legally present parents to have undocumented children, and we did not allow a legally present older sibling to have an undocumented younger sibling. We then sampled from the resulting pool of candidates to match the U.S. population targets for undocumented adults and children, as reported by the Migration Policy Institute (MPI, undated-a). This step produced a realistic set of undocumented individuals that is valid for the United States. We then reweighted the CPS data to look like Connecticut by including marginal distributions of the undocumented immigrant population that are specific to Connecticut, documented by MPI, in the reweighting scheme. The variables included in the reweighting are age, gender, income level, years of residence in the United States, and insurance coverage status (insured versus uninsured).

The other immigration variable that required some imputation was the number of years of residence in the United States, which we used to identify *legally present recent immigrants*, defined as those who have been in the country for fewer than five years. Although the CPS contains a variable that reports an individual's date of arrival in the United States, this variable appears to be noisy and is often in conflict with Medicaid status and the state-specific restrictions on Medicaid eligibility for recent immigrants (KFF, 2021). Thus, we assumed that when there was a conflict between years of residence and Medicaid status, Medicaid status had been correctly reported. We then modified the individual's years of residence to be greater than five.

### *Pregnancy Status*

We imputed pregnancy status by estimating the probability of being pregnant, conditional on several individual characteristics, and sampling such a probability to assign pregnancy status to each woman aged 15 to 45 years. We started with publicly available 2019 fertility rates by age, race, and ethnicity (Connecticut Department of Public Health, undated). However, these data do not capture other social determinants of fertility, such as education, marital status, or country of birth. Therefore, we used the iterative proportional fitting (IPF) procedure to combine the fertility rates by age, race, and ethnicity with additional information about the socioeconomic status of the pregnant mother, which was also provided by the Connecticut Department of Public Health. As a result, we were able to sample pregnancy status as a function of age, race, ethnicity, education, marital status, and U.S. nativity.

### **Reweighting of COMPARE Model**

The COMPARE microsimulation model was originally designed to be representative of the United States. To adapt it to the state of Connecticut, we used a reweighting methodology that has been applied numerous times to produce state-specific simulation results (Auerbach et al., 2011; Nowak et al., 2017; Rao, Eibner, and Nowak, 2018). The idea behind reweighting is that the nationally representative COMPARE simulation already contains all the *types* of individuals that are present in Connecticut but not in state-specific proportions. The individual types are defined by age, race, gender, and ethnicity, as well as detailed insurance status. We used two sources of data to reassign the weight of the individuals in the COMPARE simulation in such a

way that the distribution of relevant individual characteristics matched the Connecticut distribution:

- Connecticut-specific demographic and insurance enrollment information gathered for prior analyses (Rao, Girosi, and Eibner, 2021; Rao et al., 2022)
- Connecticut-specific imputed immigration status, as described above.

We used the IPF algorithm to implement the reweighting. Because the number of marginal values reweighted by the IPF algorithm was small compared with the number of CPS records (approximately 158,000), the algorithm converged without issue. We then validated the accuracy of the reweighting procedure by comparing the desired distribution of individual characteristics with the distribution observed in the reweighted COMPARE data. The IPF algorithm is very accurate in matching the desired marginal distribution, with an error that is below the uncertainty level intrinsic to the simulation. However, the error in reproducing the overall distribution of the relevant variables for Connecticut remains undetermined, because we could not observe the underlying joint distribution and had no basis for comparison.

We used 2019 data representing Connecticut as our baseline for reweighting the COMPARE microsimulation model, and we report simulation results for the year 2023. We used 2019 as the baseline year because the national forecasted unemployment rate for the year 2023 (3.7 percent) is similar to the actual unemployment rate for 2019 (3.5 percent) (Board of Governors of the Federal Reserve System, 2021). We did not use 2020 for our baseline year for reweighting because the short-term effects of the COVID-19 pandemic and related policy changes made data from that year unrepresentative. For example, unemployment spiked in the spring of 2020 (Bureau of Labor Statistics, 2021).

## Current Law Policy Scenario

For each policy scenario that we simulated in COMPARE (described in Table 3.1), we compared the outcomes of that scenario with a current law scenario, which is intended to represent the status quo projected to 2023. For these analyses, we note that the current law scenario incorporates two recently passed policies in Connecticut: (1) a policy that extends Medicaid eligibility to children eight years of age or under and pregnant persons who would qualify for Medicaid but for their immigration status,<sup>5</sup> and (2) Covered Connecticut, a policy that offers \$0 premiums and 0 percent cost-sharing for silver plans on the state's health insurance marketplace for those with incomes up to 175 percent of FPL.

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<sup>5</sup> In May 2022, the Connecticut House and Senate approved an expansion to this program such that Medicaid eligibility is further extended to children aged 12 and younger, and individuals who sign up for coverage by age 12 would not age out of the program until age 19 (Carlesso, 2022). This most-recent expansion was not included in the analyses described in this report.

**Table 3.1. Policy Scenarios for Undocumented and Legally Present Recent Immigrants**

<b>Policy Scenario</b>	<b>Medicaid Eligibility</b>	<b>Subsidy Eligibility</b>
Current law	<ul style="list-style-type: none"> <li>• Undocumented pregnant persons and children aged 8 and under who qualify based on income</li> <li>• Legally present recent immigrants who are pregnant who qualify based on income</li> <li>• Legally present recent immigrants under the age of 21 who qualify based on income</li> </ul>	<ul style="list-style-type: none"> <li>• Only legally present recent immigrants who qualify based on income and do not have another source of affordable coverage</li> </ul>
Scenario 1: Medicaid only	<ul style="list-style-type: none"> <li>• Entire population (i.e., undocumented and legally present recent immigrants) who qualify based on income</li> </ul>	<ul style="list-style-type: none"> <li>• Only legally present recent immigrants who qualify based on income and do not have another source of affordable coverage</li> </ul>
Scenario 2: Medicaid + IM 200	<ul style="list-style-type: none"> <li>• Entire population who qualify based on income</li> </ul>	<ul style="list-style-type: none"> <li>• Legally present recent immigrants who qualify based on income and do not have another source of affordable coverage</li> <li>• Undocumented immigrants with incomes less than 200% of FPL and do not have another source of affordable coverage</li> </ul>
Scenario 3: Medicaid + IM 400	<ul style="list-style-type: none"> <li>• Entire population who qualify based on income</li> </ul>	<ul style="list-style-type: none"> <li>• Entire population who qualify based on income and do not have another source of affordable coverage</li> </ul>

NOTE: IM 200 = individual market subsidy eligibility for individuals with incomes less than 200% of FPL; IM 400 = individual market subsidy eligibility for individuals with incomes less than 400% of FPL.

## Medicaid and Individual Market Subsidy Expansion Scenarios

### *Medicaid Eligibility*

Eligibility for Connecticut’s Medicaid program, HUSKY, is described in Table 3.2. All of the expansion scenarios would expand eligibility for HUSKY to undocumented and legally present recent immigrants who otherwise qualify based on income.

**Table 3.2. Medicaid Income Eligibility**

<b>Medicaid Program</b>	<b>Population Covered</b>	<b>Income Eligibility</b>
HUSKY A	Parents/caregivers	Less than 160% of FPL
	Children	Less than 201% of FPL
	Pregnant persons	Less than 263% of FPL
HUSKY B (CHIP)	Children	Less than 323% of FPL
HUSKY D (expansion population)	Adults without minor children	Less than 138% of FPL

## *Individual Market Subsidies*

We modeled the individual market reforms to be structured in a similar way to the reforms currently under consideration in Colorado. We assumed that undocumented immigrants would enroll in an off-marketplace version of a standardized plan that would be offered on the bronze, silver, and gold metal tiers and would receive subsidies funded entirely by the state. Because there are currently no restrictions to off-marketplace individual market enrollment based on immigration status, this would not require any further policy change. In addition, because the state would directly fund the CSR subsidies, they would not be loaded onto the off-marketplace silver plan. APTCs for the off-marketplace plan would be calculated based on the off-marketplace second-lowest-cost silver plan.

Eligibility for individual market subsidies depends both on income level and availability of another source of affordable coverage. CSR subsidies are available to individuals with incomes less than 250 percent of FPL, and APTCs are available to individuals with incomes less than 400 percent of FPL,<sup>6</sup> who do not have another source of affordable coverage, including Medicaid or ESI.

## *Uncertainties Related to This Analysis*

Two key variables that are important for our analysis are the expected insurance take-up rate and the average health care spending among the undocumented immigrant population. It is difficult to pin down accurate estimates for each of these. We explain next how we have accounted for these uncertainties in our modeling.

### **Public Insurance Take-Up Rate**

Historically, undocumented immigrants have been ineligible for most forms of public health insurance, making it difficult to estimate the expected take-up rate for Medicaid coverage among this population. In general, beyond the difficulties that legally present recent immigrants may face when trying to enroll in health insurance (e.g., language barriers, lack of understanding of available options, or how to enroll), undocumented immigrants are likely to have even lower take-up rates based on their fears of potential immigration enforcement actions (Whitener, 2020).

Although many states, including Connecticut, offer emergency Medicaid coverage to undocumented immigrants, this coverage generally only applies to acute health emergencies and pregnancy-related services. Therefore, it is likely that individuals only take up this coverage at the time when such services are needed; this makes it impossible to calculate a take-up rate for emergency Medicaid services because the number of eligible individuals (i.e., the denominator) is unknown. Estimates of Medicaid take-up rates are available from a few states. For example, in California, 2021 enrollment data for undocumented young adults (California Health and Human

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<sup>6</sup> The ARP enhanced APTCs by removing the maximum income limit for receipt of APTCs through 2022. Our main analyses assume that this enhancement is no longer in effect by 2023.

Services, 2022), compared with estimates of the eligible population (Legislative Analyst's Office, 2018), suggest a take-up rate of 81.6 percent. Compared with the general take-up rate in California of approximately 91 percent (Haley et al., 2021), this suggests a take-up rate among undocumented immigrants that is approximately 10.5 percent lower than among the general population. On the other hand, estimates from Oregon, based on its expansion of Medicaid coverage to undocumented children, show a projected take-up rate of 43 percent two years after the program was introduced, compared with a general take-up rate of 93 percent among children residing in Oregon in 2019 (Whitener, 2020; Haley et al., 2021). These figures suggest that the take-up rate among undocumented immigrants in Oregon is 50 percent lower than among the general population. This striking variability suggests that even looking to other states that have expanded full-scope Medicaid to some portion of the undocumented immigrant population provides limited information on take-up rates. First, there is wide variation in take-up rate estimates. Second, although states may have good enrollment data for undocumented individuals, eligibility is still difficult to estimate accurately for a population whose total size and underlying demographics are not known with any precision. Third, information from other states may have limited applicability for a few reasons. For example, other states may have targeted different populations over different time periods, and state-specific factors, such as outreach to the targeted population, may differ (Whitener 2020; Lucia et al., 2015; Legislative Analyst's Office, 2018).

Therefore, we looked to estimate from survey data how much lower take-up rates might be for the undocumented population than for the general population. We found two such estimates in the literature, both of which suggested that take up of government programs by undocumented immigrants could be approximately 25 percent lower than it would be for the general population (Hamel et al., 2021; Lucia, 2019). This percentage also falls roughly between the take-up rate estimates for California and Oregon. Therefore, we assumed in our modeling that undocumented immigrants' take up of Medicaid is 25 percent lower than that of the general population in Connecticut.

### Health Care Spending

Undocumented immigrants are likely to have lower health care spending than U.S. citizens and legal residents. Two reasons in particular are important for us to consider:

- the “healthy immigrant effect” (Antecol and Bedard, 2006), which refers to the fact that immigrants tend to be healthier on average than legal residents
- the fact that undocumented immigrants are far less likely to carry health insurance than legal residents (KFF, 2021), thereby making them less likely to use health care services.

In this work, it was important for us to understand these effects separately, because we would expect that as undocumented immigrants gain health insurance coverage, their use of health care services and, therefore, their health care costs would increase. Furthermore, undocumented immigrants who are inclined to enroll in health insurance might tend to have relatively high

expenditures, even if—in general—the undocumented immigrant population is healthier than the legally present population. Most estimates of health care spending or utilization among undocumented immigrants do not control for factors such as age, health status, or health insurance status. Without controlling for such factors, health care spending for undocumented immigrants appears to be two to four times lower than that of the legally present population (Flavin et al., 2018; Wilson et al., 2020). However, controlling for such factors indicates that health care spending among undocumented immigrants is only 25 percent lower than among legally present residents (Wilson et al., 2020). Therefore, we applied this estimate of health care spending among undocumented immigrants in our modeling.

### *Sensitivity Analysis*

Given the uncertainties around health insurance take-up rates and health care spending among the undocumented immigrant population, we ran four sets of sensitivity analyses, as described in Table 3.3. Essentially, we varied the take-up and spending rates by 10 percentage points in either direction. Although the take-up rates suggested by California and Oregon data were outside of these bounds, it seemed that the particular circumstances in California (i.e., an existing very high take-up rate of emergency Medicaid services) were likely to make its estimate an outlier on the high end. On the other hand, the relatively low take-up rate in Oregon likely stemmed from the fact that it represented utilization during only the first two years of Oregon’s expansion program.

**Table 3.3. Sensitivity Analyses**

Variable	Assumptions				
	Baseline	Low Take-Up Rate	High Take-Up Rate	Low Spending	High Spending
Take-up rate	25% lower than general population	35% lower than general population	15% lower than general population	25% lower than general population	25% lower than general population
Health care spending	25% lower than general population	25% lower than general population	25% lower than general population	35% lower than general population	15% lower than general population

### *ARP–Enhanced Subsidies*

For each policy scenario in the baseline analysis, we assumed that changes in the amount and structure of APTCs (as described in the previous chapter) that are in place for 2021 and 2022 due to the ARP will expire as planned at the end of 2022. Although the Build Back Better Act, which would have continued these subsidy enhancements, did not receive sufficient support from the U.S. Senate, it is possible that individual policy efforts may be incorporated into future legislation. Furthermore, current Connecticut policy proposals assume that the ARP subsidy

enhancements will be in place after 2023.<sup>7</sup> Therefore, we ran one additional set of analyses, which assumes that take-up rates and health care spending are the same as the levels in the main analysis while ARP subsidy enhancements continue beyond 2022.

## Reported Outcomes

We used COMPARE to generate outputs on insurance enrollment, insurance transitions, premiums, costs to the state government, and impacts on hospital spending. More specifically, we calculated the following outcomes for each policy scenario, as well as for the current-law scenario:

- insurance enrollment by coverage category based on individuals' and families' insurance choices given their available options
- insurance transitions relative to current law
- individual market plan premiums calculated within the model based on the risk pool of those enrolling in the individual market
- cost to state government calculated within the model based on the health care spending of individuals who enroll in Medicaid, plus the state's subsidy spending on APTCs and CSRs
- high-level impact on hospital spending on uncompensated care, which we calculated by drawing on estimates of uncompensated care provided by hospitals in Connecticut produced by the Connecticut Health Policy Project (Andrews, 2020) and estimates of the total uninsured population in the state of Connecticut calculated by Kaiser Family Foundation (KFF, undated-a). We made two major assumptions:
  - all uncompensated care in Connecticut was provided to uninsured individuals
  - individuals who newly gained insurance in our policy scenarios had hospital spending that was 25 percent lower than the average hospital spending on uncompensated care per person under current law.

This approach did not account for unpaid patient OOP costs among insured patients, because we did not have information on specific categories of uncompensated care.

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<sup>7</sup> See, for example, the state's current demonstration waiver application to continue the Covered Connecticut program (Connecticut Department of Social Services, 2022).

## 4. Results

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### Enrollment and Take-Up Rate

#### *Enrollment*

Under current law, more than one-half of the undocumented and legally present recent immigrant population was uninsured (Table 4.1). Of the 49,400 individuals in the population who had insurance under current law, the majority (43,200) were covered by ESI. An additional 5,400 individuals had off-marketplace individual market coverage (of which only 200 were subsidized legally present recent immigrants), while 800 children and pregnant persons were enrolled in Medicaid.

In Scenario 1, in which Medicaid eligibility is expanded to all otherwise-eligible individuals regardless of immigration status, total insurance coverage increases to 70,800 individuals. This is largely driven by a substantial increase of 28,100 individuals with Medicaid coverage relative to current law. ESI coverage and individual market coverage both drop by a few thousand people as they gain Medicaid eligibility. Uninsurance falls by more than 21,400 individuals relative to current law.

In Scenario 2, which removes the immigration status requirement for individual market subsidies for individuals with incomes less than 200 percent of FPL, total insurance enrollment increases by 23,600 (to a total of 73,000 individuals) compared with current law. ESI, Medicaid, and individual market unsubsidized enrollment are all similar to levels under Scenario 1, but 2,600 individuals enroll in subsidized individual market coverage.

Scenario 3 further expands individual market subsidy eligibility to all individuals who otherwise qualify, regardless of immigration status; total insurance enrollment increases by 24,400 compared with current law (to a total of 73,800 individuals). The results are very similar to those of Scenario 2, but there is a higher increase in subsidized individual market coverage (4,400 individuals) compared with current law because of broader eligibility. Among all other legally present residents under age 65, the total number of residents who carry health insurance changes by less than 500 across all three scenarios relative to current law (data not shown).

**Table 4.1. Insurance Enrollment Among Undocumented and Legally Present Recent Immigrants, 2023**

	Current Law	Scenario 1: Medicaid Only		Scenario 2: Medicaid + IM 200		Scenario 3: Medicaid + IM 400	
	<i>N</i>	<i>N</i>	Change from Current Law	<i>N</i>	Change from Current Law	<i>N</i>	Change from Current Law
Total insured	49,400	70,800	+21,400	73,000	+23,600	73,800	+24,400
ESI	43,200	39,100	-4,100	39,000	-4,200	39,000	-4,200
Medicaid	800	28,900	+28,100	28,900	+28,100	28,900	+28,100
Individual market	5,400	2,800	-2,600	5,100	-300	5,900	+500
Subsidized	200	0	-200	2,600	+2,400	4,400	+4,200
Unsubsidized	5,200	2,800	-2,400	2,500	-2,700	1,500	-3,700
Uninsured	66,300	44,900	-21,400	42,700	-23,600	41,900	-24,400

NOTE: IM 200 = individual market subsidy eligibility for individuals with incomes less than 200% of FPL; IM 400 = individual market subsidy eligibility for individuals with incomes less than 400% of FPL.

*Uninsurance Rate by Age and Income*

We calculated the uninsurance rate by age group and income category (Table 4.2). Uninsurance rates for children drop dramatically from 39 percent under current law to 17 percent across the three policy scenarios. Among the remaining age groups, the decline in uninsurance ranges from 14 to 20 percentage points when Medicaid eligibility is expanded; expansion of individual market subsidies further reduces uninsurance by a few percentage points.

Predictably, under current law, uninsurance rates are the highest among the lowest-income individuals and decline as income increases. Under each scenario, uninsurance declines substantially for individuals with incomes under 139 percent of FPL (from 82 percent under current law to 37 percent in each scenario). The decline in uninsurance becomes smaller with each subsequent income group, because the policies that we studied impact individuals with the lowest incomes the most.

**Table 4.2. Uninsurance Rates, by Age and Income, Among Undocumented and Legally Present Recent Immigrants, 2023**

	Current Law	Scenario 1: Medicaid Only	Scenario 2: Medicaid + IM 200	Scenario 3: Medicaid + IM 400
Age group				
0–18	39%	17%	17%	17%
19–24	66%	52%	50%	49%
25–54	57%	37%	36%	35%
55+	68%	53%	50%	49%

	<b>Current Law</b>	<b>Scenario 1: Medicaid Only</b>	<b>Scenario 2: Medicaid + IM 200</b>	<b>Scenario 3: Medicaid + IM 400</b>
Income group				
<139% of FPL	82%	37%	37%	37%
139–250% of FPL	67%	54%	46%	44%
251–400% of FPL	50%	48%	48%	45%
401%+ of FPL	19%	19%	19%	19%

NOTE: IM 200 = individual market subsidy eligibility for individuals with incomes less than 200% of FPL; IM 400 = individual market subsidy eligibility for individuals with incomes less than 400% of FPL.

### *Medicaid Take-Up Rate*

We calculated the Medicaid take-up rates as the number of individuals eligible and enrolled in Medicaid divided by the number of individuals eligible and enrolled in Medicaid plus the number of individuals eligible for Medicaid but uninsured, consistent with prior work on this subject (Haley et al., 2021). In particular, we determined eligibility based on the reported income and family size in the CPS data; individuals who reported receipt of Medicaid but whose income and/or family size indicated that they were not eligible were excluded from our calculation of take-up rate. We found that among U.S. citizens and legal residents of more than five years, the Medicaid take-up rate is 92.7 percent, consistent with existing estimates (Haley et al., 2021). The take-up rate for undocumented immigrants is approximately 25 percentage points lower as a result of the adjustment that we applied.

### *Insurance Transitions*

Table 4.3 shows insurance status transitions among undocumented and legally present recent immigrants under current law (along the left) to each policy scenario (across the top). Across all three scenarios, among new Medicaid enrollees, 3,900 individuals were previously insured via ESI, 2,400 individuals were previously covered by unsubsidized individual market coverage, and 21,600 individuals were previously uninsured. In Scenario 2, among individuals who moved into subsidized individual market coverage, 200 previously received ESI, 300 previously received unsubsidized individual market coverage, and 2,100 were previously uninsured. In Scenario 3, among individuals who moved into subsidized individual market coverage, 200 were previously on ESI, 700 were previously on unsubsidized individual market coverage, and 3,400 were previously uninsured.

**Table 4.3. Insurance Status Under Current Law Among Undocumented and Legally Present Recent Immigrants Who Enroll in Medicaid or Subsidized Individual Market Coverage, 2023**

Insurance Status	Scenario 1: Medicaid Only		Scenario 2: Medicaid + IM 200				Scenario 3: Medicaid + IM 400			
	Medicaid (N = 28,900)		Medicaid (N = 28,900)		Individual Market, Subsidized (N = 2,600)		Medicaid (N = 28,900)		Individual Market, Subsidized (N = 4,400)	
	<i>n</i>	%	<i>n</i>	%	<i>n</i>	%	<i>n</i>	%	<i>n</i>	%
Medicaid	800	3%	800	3%	0	0%	800	3%	0	0%
ESI	3,900	13%	3,900	13%	200	8%	3,900	13%	200	5%
Individual market, unsubsidized	2,400	8%	2,400	8%	300	12%	2,400	8%	700	16%
Individual market, subsidized	200	1%	200	1%	0	0%	200	1%	0	0%
Uninsured	21,600	75%	21,600	74%	2,100	81%	21,600	74%	3,400	79%

NOTE: *ns* may not sum correctly because of rounding. IM 200 = individual market subsidy eligibility for individuals with incomes less than 200% of FPL; IM 400 = individual market subsidy eligibility for individuals with incomes less than 400% of FPL.

## Premiums

Although undocumented immigrants would only be permitted to enroll in off-marketplace plans (as they can under current law as well), the availability of subsidies causes an increase in enrollment and the availability of Medicaid causes some disenrollment from the individual market among those who gain Medicaid eligibility. Because individual market premiums (both on- and off-marketplace) are determined by the same risk pools, changes in enrollment among undocumented or legally present recent immigrants can lead to changes in premiums across the individual market. However, the relatively small changes in overall individual market enrollment as a result of the scenarios that we examined lead to very small changes in individual market premiums (Table 4.4).<sup>8</sup> Compared with current law, premiums both on- and off-marketplace change by less than \$40 annually across all three scenarios. In Scenario 1, in which there are no changes to individual market subsidy availability, individual market premiums change by the largest amount—actually less than premiums under current law. This is because the changes in

<sup>8</sup> Changes in individual market enrollment among undocumented immigrants were fewer than 2,500 individuals across all scenarios compared with the total individual market enrollment of more than 180,000 individuals in Connecticut.

individual market premiums are largely driven by individuals with higher-than-average health care costs who leave the individual market to enroll in Medicaid.

**Table 4.4. Annual Individual Market Premiums, by Plan Tier**

Plan Tier	Current Law	Scenario 1: Medicaid Only		Scenario 2: Medicaid + IM 200		Scenario 3: Medicaid + IM 400	
	Premium	Premium	Change from Current Law	Premium	Change from Current Law	Premium	Change from Current Law
Bronze	\$5,791	\$5,768	-\$23	\$5,792	\$1	\$5,802	\$11
Silver (off-marketplace)	\$6,756	\$6,730	-\$26	\$6,757	\$1	\$6,769	\$13
Silver (on-marketplace with loading)	\$10,161	\$10,141	-\$20	\$10,149	-\$12	\$10,159	-\$2
Gold	\$9,078	\$9,043	-\$35	\$9,080	\$2	\$9,096	\$18

NOTE: IM 200 = individual market subsidy eligibility for individuals with incomes less than 200% of FPL; IM 400 = individual market subsidy eligibility for individuals with incomes less than 400% of FPL.

## Costs to Connecticut and Hospital Spending on Uncompensated Care

Costs to the state to fund the insurance expansions range from \$83 million to \$121 million (Table 4.5). Across all three scenarios, the total cost to Connecticut to further expand Medicaid to all residents over the age of nine (and not pregnant), regardless of immigration status, is \$82.6 million relative to current law (for comparison, this is 3 percent of the nearly \$3 billion in the state’s budget for Medicaid for fiscal year 2023 [Connecticut General Assembly, 2021b]). Broken out by age group, \$10.0 million covers children aged 9–18, \$7.8 million covers young adults aged 19–24, \$60.0 million covers adults aged 25–54, and \$4.9 million covers adults aged 55 and older. Of the costs for adults aged 55 and older, the majority are for those aged 55–64; only \$0.2 million is needed to cover adults aged 65 and older.

In Scenarios 2 and 3, in which individual market subsidies are expanded, the state also incurs costs for subsidy funding. In Scenario 2, in which subsidies are extended to undocumented residents who otherwise qualify with incomes under 200 percent of FPL, costs to the state are \$26.7 million for APTCs and CSRs. In comparison, the state spends \$46.0 million to fund supplemental subsidies to legal residents under Covered Connecticut (data not shown). In Scenario 3, in which subsidies are extended to undocumented residents who otherwise qualify with incomes under 400 percent of FPL, costs to the state are \$38.0 million for APTCs and CSRs.

We did observe a minor increase in Medicaid enrollment and subsequent costs to the state for legally present recent immigrants (data not shown). This is due to a slight downward shift in ESI enrollment in each scenario compared with current law (a decrease of 3,000 to 3,500 individuals, relative to total ESI enrollment of more than 1.8 million), which is offset by increases in Medicaid and individual market enrollment. We observed that this slight shift generally occurs

among mixed-immigration status families; as the undocumented family members gain eligibility for Medicaid or the individual market subsidies, the whole family shifts its coverage.

**Table 4.5. Costs to the State, 2023 (\$ millions)**

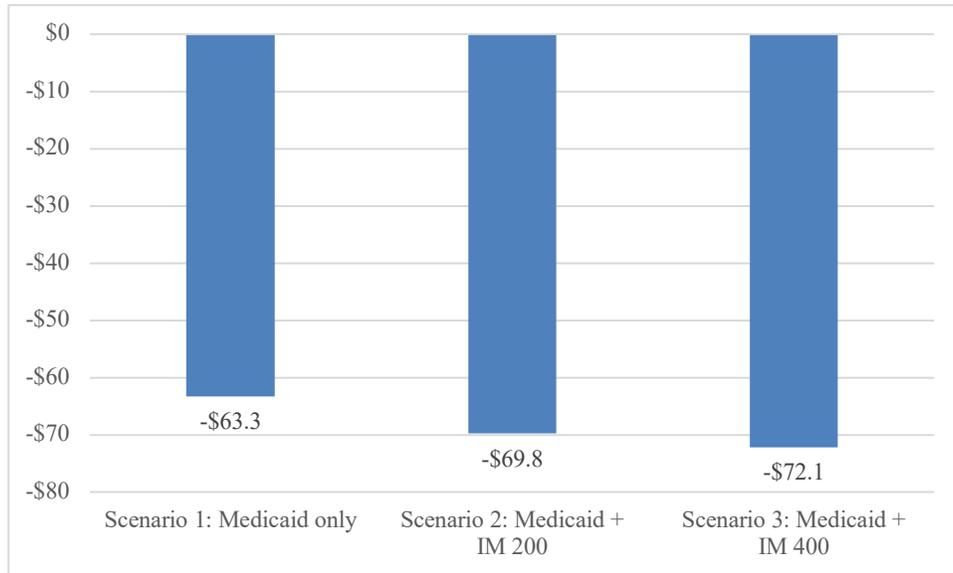
	<b>Current Law</b>	<b>Scenario 1: Medicaid Only</b>	<b>Scenario 2: Medicaid + IM 200</b>	<b>Scenario 3: Medicaid + IM 400</b>
Total cost of insurance expansions	\$1.1	\$83.7	\$110.4	\$121.7
Medicaid (undocumented and legally present recent immigrants)	\$1.1	\$83.7	\$83.7	\$83.7
Age ≤ 8 <sup>a</sup>	\$1.1	\$1.1	\$1.1	\$1.1
Ages 9–18 <sup>a</sup>	\$0.0	\$10.0	\$10.0	\$10.0
Ages 19–24 <sup>a</sup>	\$0.0	\$7.8	\$7.8	\$7.8
Ages 25–54	\$0.0	\$60.0	\$60.0	\$60.0
Ages 55+	\$0.0	\$4.9	\$4.9	\$4.9
Ages 65+ <sup>a</sup>	\$0.0	\$0.2	\$0.2	\$0.2
Individual market (undocumented immigrants)	\$0.0	\$0.0	\$26.7	\$38.0
APTC spending on undocumented	\$0.0	\$0.0	\$21.0	\$32.3
CSR spending on undocumented	\$0.0	\$0.0	\$5.7	\$5.7

NOTE: IM 200 = individual market subsidy eligibility for individuals with incomes less than 200% of FPL; IM 400 = individual market subsidy eligibility for individuals with incomes less than 400% of FPL.

<sup>a</sup> To estimate the size of this population, we assumed that the distribution of age within broader age categories were the same as they are for legal residents. The other age groupings in this table align with the age groupings in the MPI's estimates of the size of the undocumented immigrant population in Connecticut.

Figure 4.1 displays the high-level impact of each scenario on hospital spending on uncompensated care. Because we calculated hospital spending on uncompensated care based on the number of uninsured individuals in the state, changes in uninsurance directly impact hospital spending on uncompensated care. The number of uninsured undocumented and legally present recent immigrants decreases across scenarios; similarly, hospital spending on uncompensated care falls by \$63 million (Scenario 1) to \$72 million (Scenario 3) relative to total hospital spending on uncompensated care of \$197 million for this population under current law.

**Figure 4.1. Decline in Hospital Spending on Uncompensated Care for Undocumented and Legally Present Recent Immigrants Across Scenarios Relative to Current Law (\$ millions)**



NOTE: IM 200 = individual market subsidy eligibility for individuals with incomes less than 200% of FPL; IM 400 = individual market subsidy eligibility for individuals with incomes less than 400% of FPL.

## Profile of Newly Insured and Remaining Uninsured Undocumented Immigrants

Table 4.6 provides a profile of the newly insured and remaining uninsured undocumented and legally present recent immigrant populations. Among the newly insured population, the distributions of age and gender are relatively similar across the three scenarios. In Scenario 1, the income distribution is skewed more heavily toward the lowest-income group (less than 139 percent of FPL), because this is the primary group that becomes eligible for Medicaid, compared with the other two scenarios in which individual market subsidy eligibility is expanded to undocumented immigrants.

Among the remaining uninsured population, the age and gender differences across the three scenarios are again similar, while the income distribution skews slightly toward higher incomes in Scenarios 2 and 3 compared with Scenario 1. The age and gender distributions are not substantially different from the distributions for individuals uninsured under current law.

**Table 4.6. Demographics of Newly Insured and Remaining Uninsured Undocumented and Legally Present Recent Immigrant Populations**

	Current Law		Scenario 1: Medicaid Only		Scenario 2: Medicaid + IM 200		Scenario 3: Medicaid + IM 400	
<b>Newly insured</b>								
<i>N</i>			21,600		23,800		25,100	
Age group	<i>n</i>	%	<i>n</i>	%	<i>n</i>	%	<i>n</i>	%
≤ 8 <sup>a</sup>	0	0.0%	0	0.0%	0	0.0%	0	0.0%
9–18 <sup>a</sup>	2,400	11.1%	2,400	10.1%	2,400	10.1%	2,400	9.6%
19–24 <sup>a</sup>	2,100	9.7%	2,400	10.1%	2,400	10.1%	2,700	10.8%
25–54	15,700	72.7%	17,100	71.8%	17,100	71.8%	18,000	71.7%
55+	1,500	6.9%	1,800	7.6%	1,800	7.6%	2,000	8.0%
65+ <sup>a</sup>	200	0.9%	200	0.8%	200	0.8%	200	0.8%
Gender	N/A							
Female	10,400	48.1%	11,000	46.2%	11,000	46.2%	11,600	46.2%
Male	11,200	51.9%	12,800	53.8%	12,800	53.8%	13,400	53.4%
Income level								
<139% of FPL	17,100	79.2%	17,200	72.3%	17,200	72.3%	17,200	68.5%
139–250% of FPL	4,000	18.5%	6,100	25.6%	6,100	25.6%	6,700	26.7%
251–400% of FPL	500	2.3%	400	1.7%	400	1.7%	1,100	4.4%
401%+ of FPL	0	0.0%	0	0.0%	0	0.0%	0	0.0%
<b>Remaining uninsured</b>								
<i>N</i>	66,300		44,700		42,500		41,200	
Age group	<i>n</i>	%	<i>n</i>	%	<i>n</i>	%	<i>n</i>	%
≤ 8 <sup>a</sup>	700	1.1%	700	1.6%	700	1.6%	700	1.7%
9–18 <sup>a</sup>	3,400	5.1%	1,000	2.2%	1,000	2.4%	1,000	2.4%
19–24 <sup>a</sup>	9,500	14.3%	7,400	16.6%	7,100	16.7%	6,800	16.5%
25–54	45,700	68.9%	30,000	67.1%	28,600	67.3%	27,700	67.2%
55+	7,000	10.6%	5,500	12.3%	5,100	12.0%	5,000	12.1%
65+ <sup>a</sup>	2,700	4.1%	2,600	5.8%	2,500	5.9%	2,500	6.1%
Gender								
Female	25,300	38.2%	15,000	33.6%	14,400	33.9%	13,700	33.3%
Male	40,900	61.7%	29,700	66.4%	28,200	66.4%	27,500	66.7%
Income level								
<139% of FPL	31,200	47.1%	14,000	31.3%	14,000	32.9%	14,000	34.0%
139–250% of FPL	19,600	29.6%	15,700	35.1%	13,500	31.8%	12,900	31.3%
251–400% of FPL	10,200	15.4%	9,700	21.7%	9,700	22.8%	9,100	22.1%
401%+ of FPL	5,300	8.0%	5,300	11.9%	5,300	12.5%	5,300	12.9%

IM 200 = individual market subsidy eligibility for individuals with incomes less than 200% of FPL; IM 400 = individual market subsidy eligibility for individuals with incomes less than 400% of FPL.

<sup>a</sup> To estimate the size of the population aged 65+, we assumed that the distribution of age within the category 55+ is the same as it is for legal residents. The other age groupings in this table align with the age groupings in the MPI's estimates of the size of the undocumented immigrant population in Connecticut.

## Sensitivity Analyses: Take-Up Rate and Spending

### Enrollment

Table 4.7 shows insurance enrollment among undocumented and legally present recent immigrants relative to current law under each of the three scenarios based on assumptions of low take-up rate, high take-up rate, low health care spending, and high health care spending. Enrollment changes in predictable ways when we vary the take-up rate: When the take-up rate is low, Medicaid enrollment is lower by approximately 4,000 individuals, and vice versa.

Health care spending among the undocumented and recent immigrant population, on the other hand, does not substantially impact bottom-line enrollment numbers. Health care spending only affects enrollment on the individual market, because Medicaid does not charge premiums to enrollees. However, because a relatively small number of undocumented immigrants newly enroll in individual market coverage, premiums are not substantially affected, and therefore, enrollment in both the subsidized and unsubsidized individual market changes only marginally as a result of our varied assumptions related to spending.

**Table 4.7. Insurance Enrollment Among Undocumented and Legally Present Recent Immigrants Relative to Current Law Under Alternate Take-Up and Spending Assumptions**

Assumption	ESI	Medicaid	Individual Market		Uninsured
			Subsidized	Unsubsidized	
Main analyses					
Medicaid only	-4,100	28,100	-200	-2,400	-21,400
Medicaid + IM 200	-4,200	28,100	2,400	-2,700	-23,600
Medicaid + IM 400	-4,200	28,100	4,200	-3,700	-24,400
Low take-up rate					
Medicaid only	-3,800	23,900	-200	-2,400	-17,500
Medicaid + IM 200	-3,900	23,900	2,400	-2,700	-19,600
Medicaid + IM 400	-3,900	23,900	4,200	-3,700	-20,500
High take-up rate					
Medicaid only	-4,400	32,100	-200	-2,400	-25,100
Medicaid + IM 200	-4,600	32,100	2,400	-2,700	-27,300
Medicaid + IM 400	-4,600	32,100	4,200	-3,600	-28,100
Low spending					
Medicaid only	-4,200	28,100	-200	-2,300	-21,500
Medicaid + IM 200	-4,300	28,100	2,400	-2,600	-23,700
Medicaid + IM 400	-4,300	28,100	4,200	-3,500	-24,600
High spending					
Medicaid only	-4,200	28,100	-200	-2,300	-21,500
Medicaid + IM 200	-4,300	28,100	2,400	-2,600	-23,600
Medicaid + IM 400	-4,300	28,100	4,200	-3,600	-24,500

NOTE: IM 200 = individual market subsidy eligibility for individuals with incomes less than 200% of FPL; IM 400 = individual market subsidy eligibility for individuals with incomes less than 400% of FPL.

## Premiums

Table 4.8 shows individual market premiums relative to current law under each of the three scenarios with the assumptions of low take-up rate, high take-up rate, low health care spending, and high health care spending. Changes in take-up rate only have minor impacts on premiums compared with the main analyses. Changes in health care spending have a slightly larger impact on premiums. Premiums fall by less under the low-spending assumptions and by more under the high-spending assumptions. This counterintuitive finding is due to the fact that higher-cost individuals leave the individual market to enroll in Medicaid when they become eligible, so premiums fall by more *relative to current law* when health care spending is higher.

**Table 4.8. Annual Individual Market Premiums Relative to Current Law Under Alternate Take-Up and Spending Assumptions, by Plan Tier**

Assumption	Bronze	Silver (Off-Marketplace)	Silver (On-Marketplace with Loading)	Gold
Main analyses				
Medicaid only	-\$23	-\$26	-\$20	-\$35
Medicaid + IM 200	\$1	\$1	-\$12	\$2
Medicaid + IM 400	\$11	\$13	-\$2	\$18
Low take-up rate				
Medicaid only	-\$20	-\$23	-\$17	-\$35
Medicaid + IM 200	-\$4	-\$5	-\$18	-\$3
Medicaid + IM 400	\$13	\$16	\$1	\$13
High take-up rate				
Medicaid only	-\$22	-\$26	-\$19	-\$35
Medicaid + IM 200	-\$2	-\$2	-\$16	-\$3
Medicaid + IM 400	\$8	\$9	-\$5	\$13
Low spending				
Medicaid only	-\$10	-\$11	-\$4	-\$14
Medicaid + IM 200	-\$13	-\$14	-\$28	-\$19
Medicaid + IM 400	\$2	\$3	-\$12	\$5
High spending				
Medicaid only	-\$71	-\$82	-\$76	-\$111
Medicaid + IM 200	-\$22	-\$25	-\$38	-\$34
Medicaid + IM 400	\$19	\$22	\$8	\$30

NOTE: IM 200 = individual market subsidy eligibility for individuals with incomes less than 200% of FPL; IM 400 = individual market subsidy eligibility for individuals with incomes less than 400% of FPL.

## State Spending

Table 4.9 shows costs to Connecticut for undocumented and legally present recent immigrants relative to current law under each of the three scenarios based on assumptions of low take-up rate, high take-up rate, low health care spending, and high health care spending. Costs

change in predictable ways when we vary the Medicaid take-up rate: When the take-up rate is low, state spending on Medicaid is lower, and vice versa. Costs similarly change in predictable ways when we vary spending: When spending is lower, Medicaid and CSR costs are lower, and vice versa.

**Table 4.9. State Spending Relative to Current Law Under Alternate Take-Up and Spending Assumptions (\$ millions)**

<b>Assumption</b>	<b>Medicaid (Total)</b>	<b>Medicaid (Children up to Age 18)</b>	<b>APTC</b>	<b>CSR</b>
Main analyses				
Scenario 1: Medicaid only	\$82.6	\$10.0	\$0.0	\$0.0
Scenario 2: Medicaid + IM 200	\$82.6	\$10.0	\$21.0	\$5.7
Scenario 3: Medicaid + IM 400	\$82.6	\$10.0	\$32.3	\$5.7
Low take-up rate				
Scenario 1: Medicaid only	\$70.4	\$9.7	\$0.0	\$0.0
Scenario 2: Medicaid + IM 200	\$70.4	\$9.7	\$20.9	\$5.7
Scenario 3: Medicaid + IM 400	\$70.4	\$9.7	\$32.3	\$5.7
High take-up rate				
Scenario 1: Medicaid only	\$88.8	\$10.6	\$0.0	\$0.0
Scenario 2: Medicaid + IM 200	\$88.8	\$10.6	\$21.0	\$5.7
Scenario 3: Medicaid + IM 400	\$88.8	\$10.6	\$32.9	\$5.7
Low spending				
Scenario 1: Medicaid only	\$73.9	\$8.7	\$0.0	\$0.0
Scenario 2: Medicaid + IM 200	\$73.9	\$8.7	\$20.9	\$5.0
Scenario 3: Medicaid + IM 400	\$73.9	\$8.7	\$32.2	\$5.0
High spending				
Scenario 1: Medicaid only	\$93.2	\$11.3	\$0.0	\$0.0
Scenario 2: Medicaid + IM 200	\$93.2	\$11.3	\$20.9	\$6.5
Scenario 3: Medicaid + IM 400	\$93.2	\$11.3	\$32.4	\$6.5

NOTE: IM 200 = individual market subsidy eligibility for individuals with incomes less than 200% of FPL; IM 400 = individual market subsidy eligibility for individuals with incomes less than 400% of FPL.

## Additional Analyses: Incorporating ARP Subsidy Enhancements

We also conducted a set of analyses under the assumption that the ARP subsidy enhancements would continue beyond 2022. Although the ARP subsidies would reduce costs to the state for covering legally present residents, matching ARP subsidies for undocumented immigrants raises costs to the state for that population. The full set of results of these analyses can be found in Appendix B. Briefly, enrollment does not change substantially under Scenarios 1 and 2 (compared with the main analyses), although there is higher subsidized enrollment and slightly lower unsubsidized enrollment in Scenario 3 when we assumed that the ARP subsidy enhancements remain in place beyond 2022. Again, premium changes relative to current law

were minor, amounting to changes of less than \$20 annually across all scenarios. Costs to the state to expand individual market subsidies to the undocumented and legally present recent immigrant population are higher when the ARP subsidies are in place; in Scenario 2, costs to the state are \$0.8 million higher when the ARP is in place compared with when it is not, and in Scenario 3, costs are \$7.1 million higher.

## 5. Discussion

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Health insurance coverage among undocumented immigrants is substantially lower than among the general population (42 percent versus 94 percent in Connecticut in 2019) (MPI, undated-a; KFF, undated-a). Our simulation suggests that expanding Medicaid and individual market subsidy eligibility to otherwise-eligible undocumented and legally present recent immigrants will lead to an increase in coverage among this population. We estimated that expanding Medicaid alone to all residents who would be eligible but for their immigration status increases insurance coverage to 57 percent. Further expanding individual market subsidy eligibility to undocumented immigrants with incomes under 200 percent of FPL increases coverage to 59 percent and to 60 percent when expanded to undocumented immigrants with incomes up to 400 percent of FPL. This represents an increase of up to 25,000 individuals, depending on the scenario. The policy scenarios reduced uninsurance the most among children who had not been previously eligible for Medicaid (those aged 9–18 years) and among individuals with the lowest incomes. Among new enrollees in Medicaid or the individual market, roughly one-quarter previously had ESI or coverage via the individual market (unsubsidized). These changes did not substantially impact total insurance coverage among other U.S. residents in Connecticut; however, there was a very minor shift from ESI to Medicaid as mixed-immigration status families transitioned from ESI to Medicaid when their undocumented family members gained Medicaid eligibility.

Allowing undocumented immigrants to receive individual market subsidies had only a minor impact on total insurance enrollment among this population. In turn, changes in individual market premiums were negligible.

Costs to the state to extend Medicaid coverage to undocumented and legally present recent immigrants were approximately \$83 million. For comparison, this is 3 percent of the nearly \$3 billion in the state’s budget for Medicaid for fiscal year 2023 (Connecticut General Assembly, 2021b). The cost to Connecticut to additionally expand individual market subsidies to undocumented immigrants with incomes under 200 percent of FPL was \$27 million, while expanding subsidies to undocumented immigrants with incomes under 400 percent of FPL would cost the state \$38 million.

Sensitivity analyses conducted under low and high take-up rates and low and high health care spending assumptions led to expected changes: Lowering the Medicaid take-up rate decreases Medicaid enrollment by 12 percent among the undocumented immigrant population and, therefore, decreases costs to the state for Medicaid by 8 percent, and vice versa (increasing enrollment by 9 percent and costs by 11 percent). Similarly, lowering expected spending among the target population decreases costs to the state for Medicaid and for state-funded individual market subsidies (by 9 percent), and vice versa (by 10 percent).

## Policy Implications

The cost of the insurance eligibility expansions that we assessed would be borne entirely by the state. In each policy scenario, roughly one-quarter of undocumented and legally present recent immigrants newly insured by Medicaid or receiving subsidies on the individual market were previously insured via ESI or unsubsidized individual market coverage. As a result, the state will absorb costs for some individuals who would have been insured without the policy change. In Scenario 1, the cost to the state per newly insured individual is \$7,700. In Scenarios 2 and 3, as the eligibility expansions affect those with higher incomes, costs per newly insured individual increase to \$8,200 and \$8,400, respectively. This is due to the fact that individuals with higher incomes are more likely to have been previously insured via ESI or on the individual market (unsubsidized). However, health insurance coverage is not the only consideration for state policymakers; these policies would also substantially increase the affordability of health care coverage for this population, particularly for those who qualify for Medicaid. For example, an undocumented single 40-year-old with an annual income of \$15,000 (under 138 percent of FPL) would have had to spend \$5,796, or nearly 40 percent of their annual income, to purchase a bronze plan with no subsidies. Qualifying for Medicaid would allow this individual to be covered at no cost. Similarly, an undocumented single 40-year-old with an annual income of \$35,000 (approximately 250 percent of FPL) would have spent the same \$5,796 (17 percent of their income) to purchase a bronze plan. Qualifying for individual market subsidies would reduce this individual's OOP premium contribution to less than \$2,000 annually for the bronze plan (6 percent of their income).

Another consideration for policymakers is the potential cost savings from this program. We calculated the potential cost savings to hospitals on uncompensated care spending and found that they would save approximately \$50 to \$59 million across scenarios thanks to the increase in insurance coverage among undocumented and legally present recent immigrants. There are likely further savings in other parts of the health care system as well. There may also be direct savings to the state that we did not estimate in our analysis. Connecticut currently has an emergency Medicaid program that covers emergency care to those who qualify based on income, regardless of immigration status. The costs to the state for this program (approximately \$15 million in 2021) would presumably be substantially reduced by the decrease in uninsurance among undocumented and legally present recent immigrants. Furthermore, Connecticut could potentially recoup some of the federal funding for the program via a Section 1115 waiver. Furthermore, by offering Medicaid to legally present recent immigrants, the state would forego federal APTC funding for the portion of this population that would have otherwise enrolled in marketplace coverage and been eligible for subsidies. Therefore, it is possible that Connecticut could recoup some of the forgone APTC funding via a Section 1332 waiver.

## Limitations

There are several limitations associated with this analysis that are important to note. An issue somewhat unique to studying the undocumented immigrant population is the lack of detailed information on the size of this population and other demographic data, such as health insurance status and level of health care utilization, among others. We addressed such limitations in our analysis as follows:

- *Size and demographics of the population.* We used the most-detailed information available on the size and demographics of the undocumented immigrant population in Connecticut. However, there is no way to validate the accuracy of the MPI data. Furthermore, the breakdowns by age, income, and uninsurance status in that data are at a high level and do not include joint distributions. Where necessary, we assumed, for example, that distributions of age within a group were similar to that of the general population.
- *Take-up rate.* The take-up rate of public insurance among undocumented immigrants is likely to be lower than that of the general population for a number of reasons. However, it is not clear by exactly how much, and it is likely influenced by many factors, including outreach efforts by the state and federal policies on immigration and the undocumented population. Our estimate for the main analyses drew from estimates in the literature, but we also conducted sensitivity analyses with high and low take-up rate assumptions. However, although our sensitivity analyses provide ranges for likely take-up rates, they should not be considered lower or upper bounds.
- *Health care spending.* Although there are estimates in the published literature that indicate that health care spending is substantially lower among undocumented immigrants relative to the general population, most estimates do not control for insurance status. We were able to locate one such estimate, which we used for this analysis. However, we conducted sensitivity analyses to understand the impact of high and low spending assumptions.

We also note that we made several assumptions in our calculation of the impact of each policy scenario on hospital costs. Namely, we assumed that all uncompensated care provided by hospitals was provided to uninsured individuals and that undocumented individuals who were uninsured under current law and gained insurance in a given policy scenario had hospital spending that was 25 percent lower than average for the uninsured population as a whole under current law.

## Conclusion

This analysis suggests that removing immigration status requirements for Medicaid and individual market subsidy eligibility would decrease uninsurance among the undocumented and legally present recent immigrant populations by 25 to 30 percent. Costs to the state would range from \$83 to \$121 million, relative to the state's budgeted cost for Medicaid of nearly \$3 billion for fiscal year 2023. Furthermore, we estimate substantial savings to hospitals on uncompensated

care. In fact, there are likely additional savings to other parts of the health care system, and the state may be able to recoup some of the costs from forgone federal APTC payments. Overall, expanding Medicaid and individual market subsidy eligibility to individuals who would qualify were it not for their immigration status promises to improve insurance coverage and affordability in Connecticut for undocumented and legally present recent immigrant populations while not substantially affecting premiums or enrollment for all other Connecticut residents.

Our results could potentially provide insights for states other than Connecticut that are considering expanding their Medicaid programs to undocumented immigrants. However, extrapolation should be done cautiously, given that states differ widely in terms of current Medicaid eligibility limits and the size and makeup of the undocumented immigrant population. Connecticut is home to a slightly lower-than-average share of undocumented immigrants, representing 3.1 percent of the state population compared with 3.4 percent of the population nationwide.<sup>9</sup> However, Connecticut has relatively expansive thresholds for Medicaid and CHIP eligibility, with upper income limits of 160 percent of FPL for parents and 323 percent of FPL for children, compared to national medians of 138 and 255 percent of FPL, respectively (KFF, undated-b). States with larger shares of undocumented immigrants in their populations may find that the cost of expansion relative to current state Medicaid spending could be larger than we have estimated, while states with lower income-eligibility thresholds could find that costs as a percentage of Medicaid spending may be lower than we have estimated.

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<sup>9</sup> Our calculations are based on 2019 state and national estimates of the undocumented population reported by MPI, undated-b, and 2019 state and national estimates of the total population reported by the U.S. Census Bureau using American Community Survey data (MPI, 2019).

## Appendix A. Overview of the COMPARE Microsimulation Model

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### Overview

COMPARE is a microsimulation model that uses economic theory and evidence from past experience to estimate how consumers and businesses will respond to health policy changes (Cordova et al., 2013). The model has been described extensively in past RAND work, including Rao et al., 2022; Liu et al., 2020; and Eibner et al., 2019. The description that follows draws heavily from these prior studies.

The model creates a representative population of individuals, families, and firms using data from the 2020 CPS. We then assign each individual in the CPS a spending amount using the spending of a similar individual from the 2018 MEPS. We group workers into firms by matching employer characteristics reported by CPS respondents to firms included in the 2019 KFF Employer Health Benefits Survey (KFF, 2020).

When projecting outcomes for future years, we update the data to reflect population growth based on factors reported by the U.S. Census Bureau and to reflect health care cost growth using the Centers for Medicare & Medicaid Services' National Health Expenditures Accounts (U.S. Census Bureau, 2021; Centers for Medicare & Medicaid Services, 2022).

### Health Insurance Enrollment Decisions

To model individual and family health insurance enrollment decisions, COMPARE uses a utility-maximization approach, in which individuals and families weigh the costs and benefits of available options. The utility-maximization framework accounts for the value of health care consumption, premium costs, expected OOP health care spending, and financial risk associated with OOP spending.

We scale each of these components of utility to dollars and assume that they are additively separable.<sup>10</sup> We further assume that individuals' utilities are separable in consumption and health. The health-related component of the utility function is modeled as follows:

$$U_{ijk} = u(H_{ij}) - E(OOP_{ij}) - p_{ij} - [0.5 * r_k * VAR(OOP_{ij})] + Calibration_{jk}$$

Within this equation,

- $u(H_{ij})$  is the utility associated with consuming health care services for individual  $i$  under insurance option  $j$
- $k$  represents an individual's demographic group based on age and income
- $OOP_{ij}$  is the out-of-pocket spending expected

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<sup>10</sup> This approach follows that of Goldman, Buchanan, and Keeler, 2000.

- $p_{ij}$  is the individual's premium contribution (after adjusting for tax credits)
- $r_k$  is the coefficient of risk aversion for members of demographic group  $k$
- $Calibration_{jk}$  is the calibration factor under insurance option  $j$  for group  $k$ .

Possible health insurance enrollment choices ( $j$ ) under the ACA may include employer coverage (ESI), Medicaid or CHIP coverage, a private individual-market plan (including plans available on- and off-marketplace), or another source of coverage.<sup>11</sup> Individuals can also choose to forgo insurance. Not all individuals will have access to all forms of coverage. For example, access to Medicaid is contingent on eligibility, and individuals will have access to ESI only if they (or their spouse or parent) work for a business that offers insurance.

Private individual market premiums are calculated based on the health expenditures of individuals who choose to enroll. The total, unsubsidized premium is based on the plan's actuarial value (AV), enrollees' age and smoking status, and market-rating reforms implemented under the ACA (PPACA, 2013). We model three-to-one rate banding by age for adults 21 and older, with a separate age band for children and young adults under 21. We also account for the ACA's risk-adjustment requirements, which transfer funds from plans with lower-than-average actuarial risk to plans with higher-than-average actuarial risk.

The term  $Calibration_{jk}$  is a factor that adjusts utilities to match enrollment patterns observed in the 2020 CPS data after having it reweighted to match Connecticut's population statistics on age, race, gender, ethnicity, and insurance status. The term accounts for nonfinancial factors that may influence preferences for different types of insurance. Such factors include the convenience associated with enrolling in ESI and access constraints associated with Medicaid. Through our calibration process, the model accounts for the fact that not all Medicaid-eligible individuals choose to enroll, perhaps because of stigma, lack of information, or transaction costs associated with enrolling.

For this current analysis, we adjusted the calibration parameter to reduce the likelihood that undocumented individuals will enroll in Medicaid or subsidized individual marketplace coverage, relative to the legally present population. These adjustments are described in more detail in the main body of the report and are designed to capture the possibility that the undocumented population may be hesitant to self-identify to government agencies, even for the purposes of obtaining insurance.

## Health Care Spending and Premiums

We assign health care spending to individuals in the model by matching records from the CPS to records in the MEPS based on age, gender, insurance status, self-reported health status,

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<sup>11</sup> Other sources of coverage include Medicare for the nonelderly with qualifying conditions and military-related sources of coverage, such as TRICARE.

and poverty category. We augment these spending imputations with data on high-cost claims from the Society of Actuaries, to account for the fact that the MEPS underrepresents individuals with high spending. We also adjust the MEPS spending estimates to align with the National Health Expenditure Accounts, according to a procedure developed by researchers from the Agency for Healthcare Research and Quality (Sing et al., 2006; Bernard, Selden, and Pylpchuk, 2015).

When individuals change insurance status in the model, we assume that utilization will also change in response to changes in cost sharing. For example, if a person moves from being uninsured to being insured, we assume that they will use more health care services because expected OOP payments are lower for the insured population. Conversely, if someone moves from a plan with higher AV to a plan with a lower AV, we assume that they will use fewer health care services. We measure utilization in dollars to reflect health care spending. However, Medicaid payment rates are lower than rates paid by commercial payers. To account for this discrepancy, we discount total spending for individuals who transition into Medicaid from another source of coverage or uninsured status to reflect lower Medicaid payment rates. For Connecticut, we assumed this payment adjustment to be 52 percent. This is based on research showing that Medicare-to-commercial-payment rates are roughly 62 percent in Connecticut for physician services (Chernew, Hicks, and Shah, 2020) and that Medicaid-to-Medicare-payment rates are roughly 76 percent in the state (Zuckerman, Skopec, and Epstein, 2017). Multiplying the estimates results in a Connecticut-specific Medicaid-to-commercial-payment ratio of 47 percent for physician services. For hospital services, Selden, 2020, estimates that the national ratio of Medicaid to commercial payment was roughly 57 percent in 2016. According to Medicaid and CHIP Payment and Access Commission, 2017, Connecticut inpatient payments for Medicaid were roughly 80 percent of the national average. Again, by multiplying the two figures, we get a Connecticut-specific Medicaid-to-commercial-payment ratio of 46 percent for hospital services.

We generated an aggregate payment rate for all Medicaid services (relative to commercial rates) by applying these estimated rates to a breakdown of spending by service type as reported by the state of Connecticut (Connecticut Department of Social Services, 2021). We assume that the hospital rate applies to hospital spending (29 percent of the total) and the physician rate applies to all other spending, except for prescription drugs (10 percent of the total), for which we assume there is no discount. This gives us an aggregate rate of 52 percent, which reflects the following calculation:  $(0.29*0.46)+(0.61*0.47)+(1*0.10) = 0.52$ .

Our elasticities of health care spending with respect to insurance status and plan generosity are derived from the RAND Health Insurance Experiment (Manning et al., 1987).

We estimate health insurance premiums based on the spending of individuals enrolled in each health insurance risk pool and by applying rating rules and risk-adjustment factors required by the ACA. Specifically, premiums in the individual and small group markets may vary only

based on age, plan AV, smoking status, and family size.<sup>12</sup> Furthermore, risk-adjustment transfers are made across plans and insurers to redistribute payments from plans with lower-than-average actuarial risk to plans with higher-than-average actuarial risk.

Premiums in the model are calculated dynamically, such that modeled individuals are offered the opportunity to enroll in a plan, premiums are estimated based on the anticipated expenditures of enrollees, and people have the opportunity to reassess their decisions by reacting to the estimated premiums before the results are finalized. For example, if the estimated premium is high, some modeled individuals may opt to drop coverage. We allow this cycle to continue until the model reaches an equilibrium, in which enrollees' insurance choices stay the same even when they are offered the opportunity to change their decisions. This approach enables us to account for adverse selection, which occurs when people with high health care spending enroll, premiums increase, and some people disenroll in response.

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<sup>12</sup> The ACA allows a further adjustment for geography; however, we do not account for this in our model.

## Appendix B. Results with ARP Subsidy Enhancements

In this appendix, we describe the results of the analyses under the assumption that the ARP subsidy enhancements will continue beyond 2022.

### Enrollment

Table B.1 shows health insurance enrollment under current law and under the three alternate scenarios. Enrollment under current law, Scenario 1, and Scenario 2 for undocumented and legally present recent immigrants is similar to that under current law in which we assumed that the ARP subsidies would be no longer in effect in 2023. In Scenario 3, in which subsidies are extended to all undocumented immigrants who would otherwise qualify but for immigration status, total individual market coverage among undocumented and legally present recent immigrants is 6,600, compared with 5,700 under current law. The increase in enrollment is among individual who receive subsidies.

**Table B.1. Enrollment Under the Assumption That ARP Subsidies Remain in Place After 2022**

	Current Law	Scenario 1: Medicaid Only		Scenario 2: Medicaid + IM 200		Scenario 3: Medicaid + IM 400+	
	<i>N</i>	<i>N</i>	Change from Current Law	<i>N</i>	Change from Current Law	<i>N</i>	Change from Current Law
Total insured	49,700	71,100	+21,300	73,300	+23,600	74,500	+24,800
ESI	43,200	39,100	-4,100	38,900	-4,300	38,900	-4,300
Medicaid	800	29,000	+28,200	29,000	+28,200	29,000	+28,200
Individual market	5,700	2,900	-2,800	5,400	-300	6,600	+900
Subsidized	200	0	-200	2,800	+2,600	5,500	+5,300
Unsubsidized	5,500	2,900	-2,600	2,600	-2,900	1,100	-4,400
Uninsured	66,000	44,600	-21,400	42,300	-23,700	41,200	-24,800

NOTE: IM 200 = individual market subsidy eligibility for individuals with incomes less than 200% of FPL; IM 400+ = individual market subsidy eligibility for all individuals for whom the cost of the benchmark plan is greater than 8.5 percent of income.

Table B.2 shows insurance status transitions among undocumented and legally present recent immigrants from current law (along the left) to each scenario (across the top). Again, findings are similar to the findings under the assumption that the ARP subsidies end after 2022 but with higher movement from unsubsidized individual market coverage and uninsurance into subsidized individual market coverage in Scenario 3.

**Table B.2. Insurance Status Transitions Among Undocumented and Legally Present Recent Immigrants Under the Assumption That ARP Subsidies Remain in Place After 2022**

Insurance Status	Scenario 1: Medicaid Only		Scenario 2: Medicaid + IM 200				Scenario 3: Medicaid + IM 400+			
	Medicaid (N = 29,000)		Medicaid (N = 29,000)		Individual Market, Subsidized (N = 2,800)		Medicaid (N = 29,000)		Individual Market, Subsidized (N = 5,500)	
	n	%	n	%	n	%	n	%	n	%
Medicaid	800	3%	800	3%	0	0%	800	3%	0	0%
ESI	3,900	13%	3,900	13%	200	7%	3,900	13%	300	5%
Individual market, unsubsidized	2,500	9%	2,500	9%	300	11%	2,500	9%	1,100	20%
Individual market, subsidized	200	1%	200	1%	0	0%	200	1%	0	0%
Uninsured	21,700	75%	21,700	75%	2,300	82%	21,700	75%	4,100	75%

NOTE: *ns* may not sum correctly because of rounding. IM 200 = individual market subsidy eligibility for individuals with incomes less than 200% of FPL; IM 400+ = individual market subsidy eligibility for all individuals for whom the cost of the benchmark plan is greater than 8.5 percent of income.

## Premiums

Table B.3 shows the individual market premiums. Premiums under current law are lower than in the baseline analyses, but changes in premiums across the three scenarios relative to current law are similarly very small (less than \$20 annually in all scenarios).

**Table B.3. Individual Market Premiums Under Assumption that ARP Subsidies Remain in Place After 2022, by Plan Tier**

Plan Tier	Current Law	Scenario 1: Medicaid Only		Scenario 2: Medicaid + IM 200		Scenario 3: Medicaid + IM 400+	
	Premium	Premium	Change from Current Law	Premium	Change from Current Law	Premium	Change from Current Law
Bronze	\$5,536	\$5,527	-\$9	\$5,534	-\$2	\$5,536	\$0
Silver (off-marketplace)	\$6,459	\$6,448	-\$11	\$6,457	-\$2	\$6,459	\$0
Silver (on-marketplace with loading)	\$9,463	\$9,455	-\$8	\$9,446	-\$17	\$9,449	-\$14
Gold	\$8,679	\$8,664	-\$15	\$8,676	-\$3	\$8,679	\$0

NOTE: IM 200 = individual market subsidy eligibility for individuals with incomes less than 200% of FPL; IM 400+ = individual market subsidy eligibility for all individuals for whom the cost of the benchmark plan is greater than 8.5 percent of income.

## Costs to Connecticut and Spending on Uncompensated Care

Across all three scenarios, the total cost to Connecticut (not considering any potential savings) to further expand Medicaid to all individuals aged 9 or older regardless of immigration status is \$83.0 million, relative to current law which is very similar to the estimate from the main analysis (Table B.4). In Scenarios 2 and 3, in which individual market subsidies are expanded, the state also incurs costs for subsidy funding; these costs are higher when the ARP subsidies are in place. Although the ARP subsidies would reduce costs to the state for covering legally present residents, matching ARP subsidies for undocumented immigrants raises costs to the state for that population. In Scenario 2, in which subsidies are extended to undocumented residents who otherwise qualify with incomes under 200 percent of FPL, costs to the state are \$27.1 million for APTCs and CSRs, \$0.4 million higher than under the assumption that ARP subsidies end after 2022. In Scenario 3, in which subsidies are extended to undocumented residents who otherwise qualify with incomes under 400 percent of FPL, costs to the state are \$44.7 million for APTCs and CSRs, \$6.7 higher than in our main analyses.

**Table B.4. Costs to the State (in millions) Under the Assumption That ARP Subsidies Remain in Place After 2022, Relative to Current Law**

	Current Law	Scenario 1: Medicaid Only	Scenario 2: Medicaid + IM 200	Scenario 3: Medicaid + IM 400+
Total costs	\$1.1	\$84.1	\$111.3	\$128.9
Medicaid (undocumented and legally present recent immigrants)	\$1.1	\$84.1	\$84.1	\$84.1
Age ≤ 8 <sup>a</sup>	\$1.1	\$1.1	\$1.1	\$1.1
Ages 9–18 <sup>a</sup>	\$0.0	\$10.0	\$10.0	\$10.0
Ages 19–24 <sup>a</sup>	\$0.0	\$7.8	\$7.8	\$7.8
Ages 25–54	\$0.0	\$60.4	\$60.4	\$60.4
Ages 55+	\$0.0	\$4.9	\$4.9	\$4.9
Ages 65+ <sup>a</sup>	\$0.0	\$0.2	\$0.2	\$0.2
Individual market (undocumented and legally present recent immigrants)	\$0.0	\$0.0	\$27.1	\$44.7
APTC spending on undocumented	\$0.0	\$0.0	\$21.1	\$38.7
CSR spending on undocumented	\$0.0	\$0.0	\$6.0	\$6.0

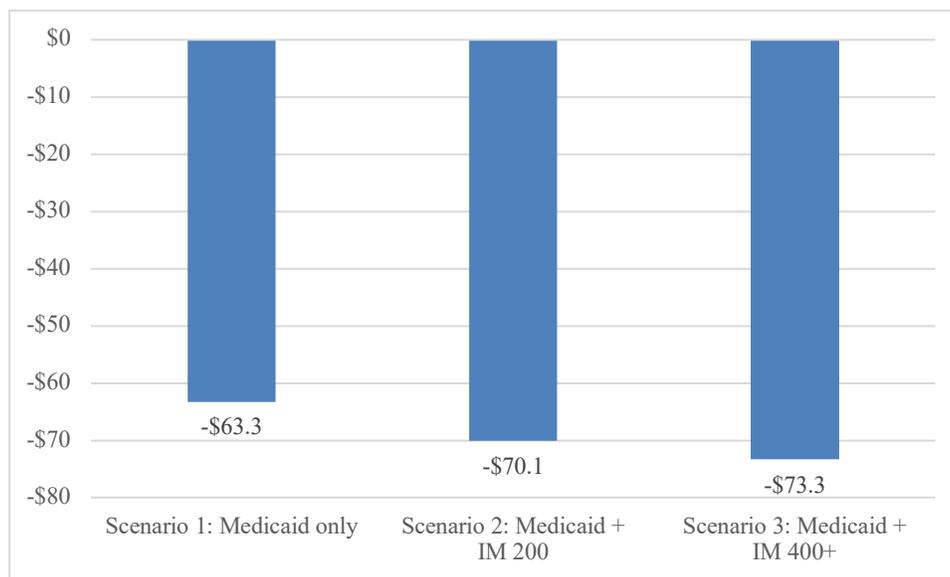
NOTE: IM 200 = individual market subsidy eligibility for individuals with incomes less than 200% of FPL; IM 400+ = individual market subsidy eligibility for all individuals for whom the cost of the benchmark plan is greater than 8.5 percent of income.

<sup>a</sup> To estimate the size of the population aged 65+, we assumed that the distribution of age within the category 55+ is the same as it is for legal residents. The other age groupings in this table align with the age groupings in the MPI's estimates of the size of the undocumented immigrant population in Connecticut.

Figure B.1 displays the high-level impact of each scenario on hospital spending on uncompensated care. The findings are very similar to those in the main analyses: Savings on

uncompensated care spending by hospitals ranges from \$63.3 million in Scenario 1 to \$73.3 million in Scenario 3.

**Figure B.1. Hospital Spending on Uncompensated Care for Undocumented and Legally Present Recent Immigrants Relative to Current Law (\$ millions)**



NOTE: IM 200 = individual market subsidy eligibility for individuals with incomes less than 200% of FPL; IM 400+ = individual market subsidy eligibility for all individuals for whom the cost of the benchmark plan is greater than 8.5 percent of income.

## Profile of Newly Insured and Remaining Uninsured Undocumented Immigrants

Table B.5 provides a profile of the newly insured and remaining uninsured undocumented and legally present recent immigrant population. The age, gender, and income distributions of these two populations are similar to those under the main analyses.

**Table B.5. Demographics of Newly Insured and Remaining Uninsured Undocumented and Legally Present Recent Immigrant Population Under the Assumption That ARP Subsidies Remain in Place After 2022**

	Current Law	Scenario 1: Medicaid Only		Scenario 2: Medicaid + IM 200		Scenario 3: Medicaid + IM 400+	
<b>Newly insured</b>		21,700		24,000		25,800	
<i>N</i>		<i>n</i>	%	<i>n</i>	%	<i>n</i>	%
Age group	N/A						
≤ 8 <sup>a</sup>		0	0.0%	0	0.0%	0	0.0%
9–18 <sup>a</sup>		2,400	11.1%	2,400	10.0%	2,400	9.3%
19–24 <sup>a</sup>		2,100	9.7%	2,500	10.4%	2,800	10.9%

	Current Law		Scenario 1: Medicaid Only		Scenario 2: Medicaid + IM 200		Scenario 3: Medicaid + IM 400+	
25–54			15,700	72.4%	17,300	72.1%	18,500	71.7%
55+			1,500	6.9%	1,900	7.9%	2,200	8.5%
65+ <sup>a</sup>			200	0.9%	200	0.8%	200	0.8%
Gender								
Female			10,400	47.9%	11,000	45.8%	11,800	45.7%
Male			11,300	52.1%	12,900	53.8%	14,000	54.3%
Income level								
<139% of FPL			17,200	79.3%	17,300	72.1%	17,300	67.1%
139–250% of FPL			4,000	18.4%	6,200	25.8%	6,900	26.7%
251–400% of FPL			400	1.8%	400	1.7%	1,200	4.7%
401%+ of FPL			0	0.0%	0	0.0%	400	1.6%
<b>Remaining uninsured</b>								
<i>N</i>	66,100		44,400		42,100		40,200	
Age group	<i>n</i>	%	<i>n</i>	%	<i>n</i>	%	<i>n</i>	%
≤ 8 <sup>a</sup>	700	1.1%	700	1.6%	700	1.7%	700	1.7%
9–18 <sup>a</sup>	3,400	5.2%	1,000	2.3%	1,000	2.4%	1,000	2.5%
19–24 <sup>a</sup>	9,500	14.4%	7,400	16.7%	7,000	16.6%	6,700	16.7%
25–54	45,500	68.9%	29,800	67.1%	28,200	67.0%	27,000	67.2%
55+	7,000	10.6%	5,500	12.4%	5,100	12.1%	4,800	11.9%
65+ <sup>a</sup>	2,700	4.1%	2,600	5.9%	2,500	5.9%	2,500	6.2%
Gender								
Female	25,200	38.2%	14,800	33.3%	14,200	33.7%	13,400	33.3%
Male	40,800	61.8%	29,500	66.4%	27,900	66.3%	26,800	66.7%
Income level								
<139% of FPL	31,100	47.1%	13,900	31.3%	13,800	32.8%	13,800	34.2%
139–250% of FPL	19,600	29.7%	15,600	35.1%	13,400	31.8%	12,700	31.6%
251–400% of FPL	10,100	15.3%	9,600	21.6%	9,600	22.8%	8,900	22.1%
401%+ of FPL	5,200	7.9%	5,200	11.7%	5,200	12.4%	4,800	11.9%

NOTE: IM 200 = individual market subsidy eligibility for individuals with incomes less than 200% of FPL; IM 400+ = individual market subsidy eligibility for all individuals for whom the cost of the benchmark plan is greater than 8.5 percent of income.

<sup>a</sup> To estimate the size of the population aged 65+, we assumed that the distribution of age within the category 55+ is the same as it is for legal residents. The other age groupings in this table align with the age groupings in the MPI's estimates of the size of the undocumented immigrant population in Connecticut.

## Abbreviations

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ACA	Affordable Care Act
APTC	advance premium tax credit
ARP	American Rescue Plan Act of 2021
AV	actuarial value
CHIP	Children's Health Insurance Program
CPS	Current Population Survey
CSR	cost-sharing reduction
ESI	employer-sponsored insurance
FPL	federal poverty level
IPF	iterative proportional fitting
MEPS	Medical Expenditures Panel Survey
MPI	Migration Policy Institute
OOP	out-of-pocket

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