The Impact of Health Reform and the Affordable Care Act (ACA)

on Latinos and Immigrants in the Omaha-Council Bluffs Metropolitan Area

Jim P. Stimpson, Ph.D.
Kelly Shaw-Sutherland, M.P.A
Yang Wang, M.H.E.M.

Introduction

The Latino population in the Omaha-Council Bluffs area grew by nearly 93.0% between 2000 and 2010 (1). In comparison, the White population grew by just 6.0% and Black population grew by about 14.0% during that same time period. Most of Iowa and Nebraska's foreign-born and Latino populations are concentrated in the Omaha-Council Bluffs metropolitan statistical area (MSA). Approximately 52.2% of the foreign-born population is Latino, and about 61.4% of that population is non-citizens (2). In addition, among Latinos under 18 years of age, approximately 11.5% are foreign-born, of which nearly 90.0% are non-citizens (1). In states like Iowa and Nebraska where both the foreign-born and Latino populations have experienced significant growth, access to health insurance coverage requires careful study, particularly because Latinos are the most likely of all racial and ethnic groups in the United States to be uninsured (1, 4).

In March 2010, the Patient Protection and Affordable Care Act (ACA, P.L. 111-148) as amended by the Health Care and Education Reconciliation Act of 2010 (HCERA, P.L. 111-152) (referred to hereafter as the ACA) was signed into law as the most comprehensive piece of health care reform legislation since the passage of Medicare and Medicaid legislation in 1965 (5). The main goal of the law is to expand access to health care for US citizens and legal residents. Given the scope and magnitude of the law, there is a need to understand the impact of the ACA on different populations and local areas. This fact sheet describes access to care for and the impact of recent national and state health policies on the Omaha-Council Bluffs MSA's Latino and immigrant populations.

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Insurance Coverage and Health-Related Characteristics

Historically, Latinos are among the likeliest to be uninsured. Figures 1 and 2 (page 5) provide data on insurance coverage from 2008 through 2010 by Latino origin, nativity, and citizenship status in the Omaha-Council Bluffs MSA. Figure 3 (page 6) provides data on the age distribution of insurance coverage by age category among Latinos, White, non-Latinos, and Black, non-Latinos in the Omaha-Council Bluffs MSA. Health insurance coverage consists of uninsured (no coverage), publically insured (e.g.; Medicaid, Medicare, or Military coverage), or privately insured (e.g.; employer-based or direct purchase coverage).

- Compared to non-Latinos, a higher proportion of Latinos were uninsured or publically insured, but Latinos were far less likely to have private insurance.
- Compared to the native-born population, a higher proportion of the foreign-born population was uninsured, and the foreign born were also less likely to have public or private insurance.
- Compared to foreign-born citizens, a higher proportion of foreign-born non-citizens were uninsured.
- Children and working aged adults account for most of the uninsured regardless of race or ethnicity, however, compared to White, non-Latinos, a higher proportion of children and adult Latinos and Black, non-Latinos are uninsured.

Figure 4 (page 6) compares health-related characteristics of Latinos and non-Latinos older than 18 years in the Omaha-Council Bluffs MSA in 2010.

- Compared to White, non-Latinos, a higher proportion of Latinos reported fair to poor health.
- Compared to White and Black, non-Latinos, a higher proportion of Latinos did not have a health care provider.
- Latinos were slightly more likely than White, non-Latinos to experience cost barriers, but slightly less likely to have not received a routine checkup in two or more years.

The Impact of the ACA on Latinos and Immigrants

The following selected provisions from the ACA specifically benefit Latinos (6):

- Protection from discrimination against health insurance companies and health care providers
- Improved preventive care, including access to free preventive services, wellness benefits, and elimination of co-payments for preventive services
- Investments in improved data collection on racial and ethnic minorities, increased diversity of health care professionals, and cultural competency training
- Creation of a standardized marketplace to buy insurance that provides easy-to-understand information for comparing prices, benefits, and performance of health insurance plans
- Guaranteed access to health insurance even during job loss, switching jobs, moving, or becoming ill
- Establishment of federal offices focused on minority health (National Institute of Minority Health and Office of Minority Health)
- Increased funding for community health centers, which provide care regardless of ability to pay or proof of immigration status
- Support for community health workers (promotoras), who help link members in a community to needed health care services

Nevertheless, federal legislation has gradually reduced the number of legitimate options for immigrants, particularly those who are undocumented, to participate in the health insurance market (7). In particular, the ACA restricts immigrant participation in Medicaid and for the new health insurance marketplaces starting in 2014 (8-9). For US-born citizens, Medicaid is expanded to include individuals with household income up to 133% of the federal poverty level (depending on the state), individuals can purchase health insurance through an online marketplace for insurance, and individuals with household income up to 400% of the federal poverty level can receive tax credits to purchase health insurance. Naturalized citizens with proof of citizenship are eligible for this same array of benefits. However, immigrants are subject to the following restrictions:

- Lawfully present immigrants (LPI) are subject to a 5-year waiting period (which states could choose to waive for children and pregnant women only) for Medicaid and Children's Health Insurance Program (CHIP) eligibility and for access to the health insurance marketplace. LPIs may, however, purchase health insurance coverage and receive tax credits during the 5-year waiting period. The US Department of Homeland Security must verify citizenship status.
- Undocumented immigrants are not eligible for Medicaid and are prohibited from purchasing health insurance through the online marketplace that will be available in 2014 or applying for tax credits to purchase health insurance.

State Level Strategies to Increase Access to Care for Immigrants in Iowa and Nebraska

In 2011, approximately 15 states enacted 23 laws related to immigration and health care, most of which focused on eligibility requirements for public insurance and insurance exchanges, and licensing of health care providers and interpreters (10). Several specific state policies have been passed that provide Medicaid and/or CHIP coverage to additional groups of immigrant children and pregnant women regardless of year of entry or status (11).

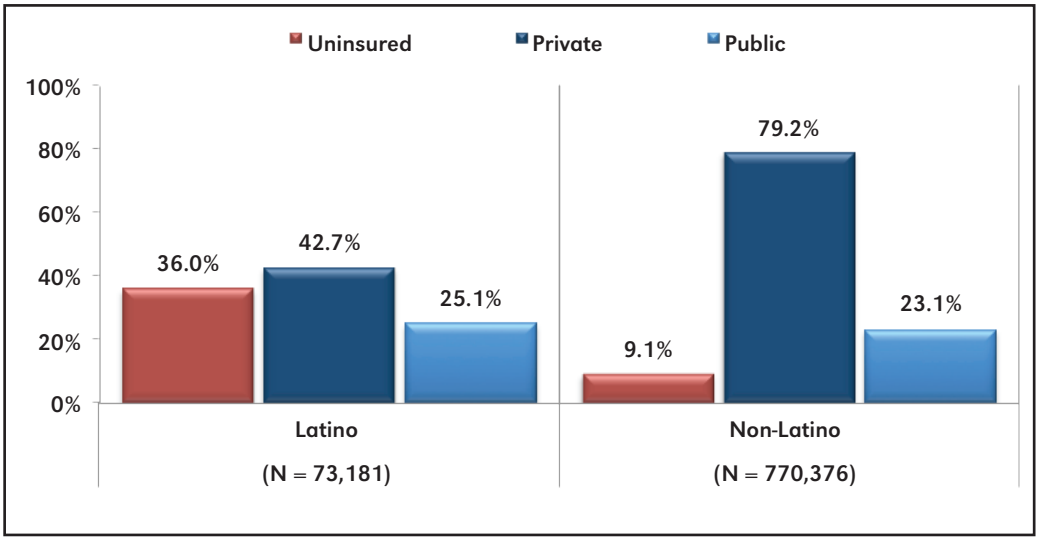
- Iowa and Nebraska provide coverage options, with federal funding, to lawfully residing children and/or pregnant women, regardless of date of entry to the US.
- Nebraska was among 13 states to receive federal CHIP funds for prenatal care to women regardless of their immigration status.
- Iowa and Nebraska provide state-only cash assistance to non-exempt, qualified, lawfully present immigrants during the 5-year waiting period.
- In April 2012, the Nebraska Unicameral upheld LB 599 to provide prenatal care to undocumented pregnant women via state funding.

Conclusion

Addressing racial and ethnic inequalities was not the primary focus of health reform, but the legislation does contain provisions to address access to care for Latinos. Under the ACA, Latinos are expected to have the largest decrease of any racial/ethnic group in rates of uninsurance, primarily through increased participation in employer-sponsored coverage, Medicaid, and the non-group market (12). In Nebraska, the uninsurance rate is expected to shrink by 50% by 2020 (13). In the Omaha/Council Bluffs area, this would translate to an uninsurance rate for Latinos of about 20% under the ACA (down from current rate of 38%), which is consistent with studies of other communities (12). However, even with full implementation of the ACA, the uninsurance rate is expected to remain significantly higher for Latinos compared to other racial/ethnic groups.

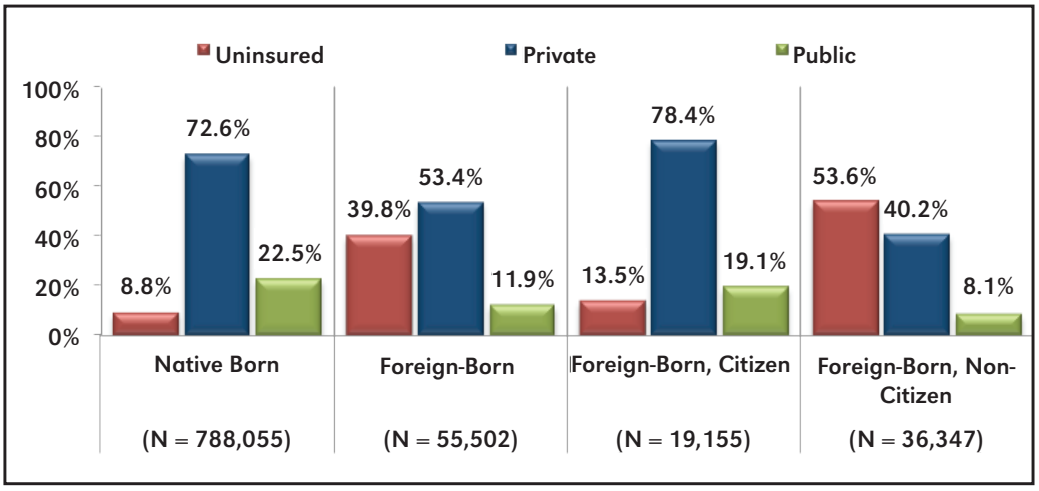
Communities will have to carefully monitor the ACA over time to ensure that provisions that are designed to benefit Latinos are fully implemented. In particular, it will be important to monitor whether Nebraska and Iowa decide to expand Medicaid, and the specific rules governing the health insurance marketplaces that will be established in each state. Even with the comprehensive reforms that are provided in the ACA, thousands of Latinos will remain uninsured, and some populations, such as undocumented immigrants, will be excluded from the insurance marketplace.

Figure 1. Percent Uninsured, Privately Insured and Publically Insured by Latino Origin, Omaha-Council Bluffs Metropolitan Statistical Area, 2008–2010



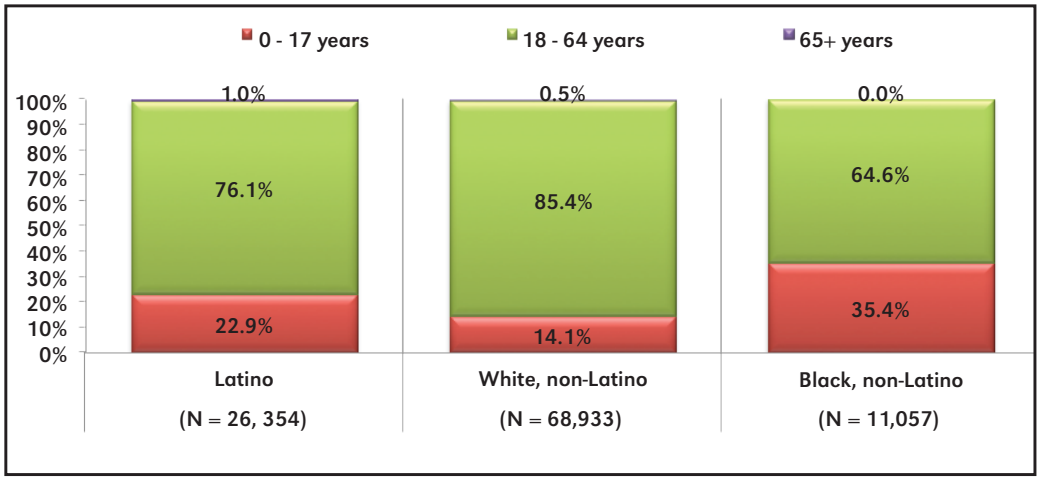
Source: U.S. Census Bureau, American Community Survey, 2008–2010.
Note: Percentages may not equal 100 due to dual insurance providers.

Figure 2. Percent Uninsured, Privately Insured and Publically Insured by Nativity and Citizenship Status, Omaha-Council Bluffs Metropolitan Statistical Area, 2008–2010



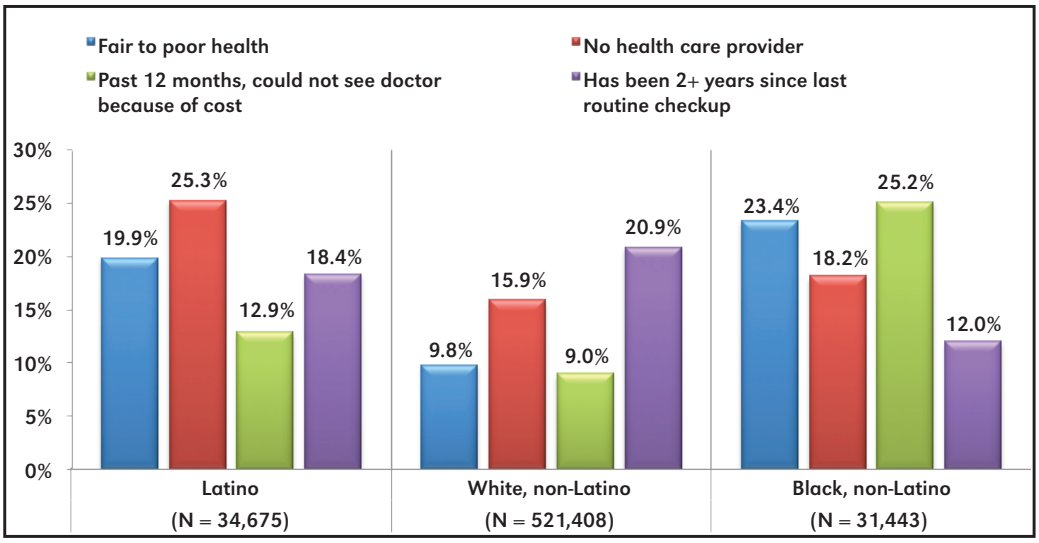
Source: U.S. Census Bureau, American Community Survey, 2008–2010.
Note: Percentages may not equal 100 due to dual insurance providers.

Figure 3. Age Distribution of the Uninsured by Latino Origin and Race Category, Omaha-Council Bluffs Metropolitan Statistical Area, 2008 - 2010



Source: U.S. Census Bureau, American Community Survey, 2008 – 2010.

Figure 4. Health-Related Characteristics of Latino and Non-Latino Populations Aged 18 Years and Older, Omaha-Council Bluffs Metropolitan Statistical Area, 2010



Source: Centers for Disease Control, Behavioral Risk Factor Surveillance System, 2010.
Note: Data are represented by weighted percentages.

Appendix A: Definitions

Foreign-born (FB):

Excluding those born abroad to U.S. citizen parents, foreign born refers to someone born outside the U.S. and its territories, and includes those who have obtained U.S. citizenship through naturalization and other persons in different immigration statuses.

Native born:

People born in the U.S., Puerto Rico, and other territories, or born abroad to U.S. citizen parents.

Immigrant:

A FB person who is not a citizen – native or naturalized – of the U.S. as defined by the Immigration and Nationality Act, Section 101 et seq.

Lawful permanent residents (LPRs):

A FB person lawfully admitted to live permanently in the U.S. by either qualifying for immigrant visas abroad or adjusting to permanent resident status in the U.S.

Naturalized citizens:

LPRs who have become U.S. citizens through the naturalization process, which typically requires living in the U.S. for five or more years to qualify, or three years if they marry citizens.

Refugees and asylees:

A FB person granted legal status due to persecution or a well-founded fear of persecution in their home countries. Refugee status is granted before entry to the U.S. Asylees usually arrive in the U.S. without authorization (or overstay a valid visa), claim asylum, and are granted asylee status once their asylum application is approved. Refugees and asylees are eligible to apply for permanent residency after one year.

Undocumented or unauthorized immigrants:

Immigrants who are not LPRs, refugees, or asylees and have not otherwise been granted permission under specific authorized temporary statuses for lawful residence and work.

Lawfully present immigrants:

The term "lawfully present" immigrants broadly include LPRs, refugees, and asylees, as well as other FB persons who are permitted to remain in the U.S. either temporarily or indefinitely but are not LPRs. Some lawfully present immigrants have entered for a temporary period, for work, as students, or because of political disruption or natural disasters in their home countries, and some may seek to adjust their status and may have a status that allows them to remain in the country but do not have the same rights as LPRs.

Qualified immigrants:

FB persons are considered for eligibility for federal benefits include: LPRs, refugees, asylees, persons paroled into the U.S. for at least one year, persons granted withholding of deportation or removal, persons granted conditional entry (before April 1, 1980), battered spouses and children (with a pending or approved spousal visa or a self-petition for relief under the Violence Against Women Act), Cuban and Haitian entrants (nationals of Cuba and Haiti who were paroled into the U.S., applied for asylum, or are in exclusion or deportation proceedings without a final order), and victims of severe human trafficking.

Nonqualified immigrants:

Immigrants who do not fall under the qualified immigrant groups, including immigrants formerly considered permanently residing under color of law (PRUCOLs), persons with temporary protected status, asylum applicants, other lawfully present immigrants (such as students and tourists), and unauthorized immigrants.

Five-year ban:

Under TANF, SNAP, Medicaid, and CHIP, post-enactment qualified immigrants, with important exemptions, are generally banned from receiving federal means-tested benefits during their first five years in the U.S. Detailed immigrant eligibility criteria for these programs are provided in the discussion and tables of the report.

Source: Fortuny, K. and Chaudry, A. (March 2012). Overview of Immigrants' Eligibility for SNAP, TANF, Medicaid, and CHIP. Prepared by the Urban Institute under contract with the Office of the Assistant Secretary for Planning and Evaluation. http://aspe.hhs.gov/hsp/11/ImmigrantAccess/Eligibility/ib.pdf retrieved on January 18, 2013.

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