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S. 1660

To expand access to health care services for immigrants by removing legal and policy barriers to health insurance coverage, and for other purposes.

IN THE SENATE OF THE UNITED STATES

MAY 17, 2021

Mr. BOOKER (for himself, Mr. MARKEY, Mrs. GILLIBRAND, Mr. MERKLEY, Mrs. MURRAY, Ms. HIRONO, Mr. SANDERS, Mr. BLUMENTHAL, and Ms. WARREN) introduced the following bill; which was read twice and referred to the Committee on Finance

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A BILL

To expand access to health care services for immigrants by removing legal and policy barriers to health insurance coverage, and for other purposes.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE.

This Act may be cited as the ''Health Equity and Access under the Law for Immigrant Families Act of 2021'' or the ''HEAL for Immigrant Families Act of 2021''.

SEC. 2. FINDINGS; PURPOSE.

(a) FINDINGS.—Congress finds as follows:

(1) Health insurance coverage reduces harmful racial, economic, gender, and health inequities by alleviating cost barriers to, and increasing utilization of, necessary health care services, especially among low-income and underserved populations.

(2) Based solely on their immigration status, many immigrants and their families face legal and policy restrictions on their ability to obtain affordable health insurance coverage through Medicaid, the Children's Health Insurance Program (CHIP), and the health insurance exchanges.

(3) Lack of health insurance coverage contributes to persistent inequities in the prevention, diagnosis, and treatment of health conditions. This leads to negative health outcomes for immigrants and their families, especially Black, Indigenous, Latinx, Asian, Pacific Islander, and other Immigrants of Color.

(4) Black immigrant women often cite cost as a major barrier to health care. Many who are undocumented forgo doctor visits altogether due to the financial burden in addition to consistent racial bias by medical practitioners and racism in health care.

(5) Nearly half of immigrant women are of reproductive age. Immigrant women, lesbian, gay, bi-

sexual, transgender, and queer (LGBTQ) immigrants, and immigrants with disabilities disproportionately live in households with low incomes and lack health insurance coverage. Legal and policy barriers to affordable health insurance coverage significantly exacerbate their risk of negative pregnancy-related and other reproductive and sexual health outcomes, with lasting health and economic consequences for immigrant women, LGBTQ immigrants, immigrants with disabilities, and their families and society as a whole.

(6) Immigrants who identify as LGBTQ experience compounding discrimination from health care providers and systems based on race and ethnicity, primary language, immigration status, sexual orientation, and gender identity. Nearly one in five transgender patients have been refused care due to their gender non-conforming status, and providers have denied care to undocumented immigrants because of immigration status. These inequities are exacerbated by legal and policy barriers that restrict access to health coverage on the basis of immigration status, exposing LGBTQ immigrant communities to disproportionate gaps in affordable, comprehensive health care. These compounding barriers

are especially harmful for LGBTQ immigrants who are escaping interpersonal and state violence due to their sexual orientation and gender identity.

(7) Denying health insurance coverage or imposing waiting periods for health insurance coverage on the basis of immigration status unfairly hinders immigrants' ability to reach and maintain their optimal levels of health and undermines the economic well-being of their families.

(8) International human rights standards hold that governments have an affirmative obligation to ensure that everyone, including immigrants, can access safe, respectful, culturally and linguistically appropriate, and high-quality pregnancy-related care, including postpartum care, free from discrimination or violence. Medicaid is the nation's single largest payer for pregnancy-related care. Nevertheless, barriers to health coverage persist for pregnant and postpartum people, particularly immigrants.

(9) Immigrants—especially Black, Indigenous, Latinx, Asian, and Pacific Islander immigrants—are among those most harmed by the United States' pregnancy-related morbidity and mortality epidemic, which is the worst among high-income nations. Black people are more than three times more likely

than white people to suffer pregnancy-related death, and twice as likely to suffer maternal morbidity. Indigenous people are more than two times more likely than white people to die from a pregnancy-related death. The majority of United States pregnancy-related deaths are preventable. Lack of access to health care, immigration status, poverty, and exposure to racism, sexism, and xenophobia in and beyond the health care system contribute to the disproportionately high number of pregnancy-related deaths among BIPOC birthing and postpartum people. Unnecessary barriers that limit pregnant and postpartum immigrants' access to health care undermine their health, safety, and human rights.

(10) One in seven United States residents is foreign-born, approximately one in four children in the United States has at least one immigrant parent, and the population of immigrant families in the United States is expected to continue to grow in the coming years. It is therefore in our collective public health and economic interest to remove legal and policy barriers to affordable health insurance coverage that are based on immigration status.

(11) Although individuals granted relief under the Deferred Action for Childhood Arrivals (DACA)

program are authorized to live and work in the United States, they have been unfairly excluded from the definitions of lawfully present and lawfully residing for purposes of health insurance coverage provided through the Department of Health and Human Services, including Medicaid, CHIP, and the health insurance exchanges.

(12) Since immigration law evolves constantly, new immigration categories for individuals with federally authorized presence in the United States may be created.

(13) Some States continue to unwisely restrict Medicaid access for immigrants who have long resided in the United States, fueling significant health inequities and increasing health care costs for individuals and the public.

(14) Congress restored Medicaid eligibility for individuals living in the United States under the Compacts of Free Association as part of bipartisan legislation in December 2020 and should build on that success by ensuring all immigrants can access care.

(b) PURPOSE.—It is the purpose of this Act to—

(1) ensure that all individuals who are lawfully present in the United States are eligible for all federally funded health care programs;

(2) advance the ability of undocumented individuals to obtain health insurance coverage through the health insurance exchanges established under part II of the Patient Protection and Affordable Care Act, Public Law 111–148;

(3) eliminate the authority for States to restrict Medicaid eligibility for lawful permanent residents; and

(4) eliminate other barriers to accessing Medicaid, CHIP, and other medical assistance.

SEC. 3. REMOVING BARRIERS TO HEALTH COVERAGE FOR LAWFULLY RESIDING INDIVIDUALS.

(a) MEDICAID.—Section 1903(v)(4) of the Social Security Act (42 U.S.C. 1396b(v)(4)) is amended—

(1) by amending subparagraph (A) to read as follows:

''(A) Notwithstanding sections 401(a), 402(b), 403, and 421 of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996, a State shall provide medical assistance under this title to individuals who are lawfully residing in the United States (including

individuals described in paragraph (1), battered individuals described in section 431(c) of such Act, and individuals with an approved or pending application for deferred action or other federally authorized presence), if they otherwise meet the eligibility requirements for medical assistance under the State plan approved under this title (other than the requirement of the receipt of aid or assistance under title IV, supplemental security income benefits under title XVI, or a State supplementary payment).'';

(2) by amending subparagraph (B) to read as follows:

''(B) No debt shall accrue under an affidavit of support against any sponsor of an individual provided medical assistance under subparagraph (A) on the basis of provision of assistance to such individual and the cost of such assistance shall not be considered as an unreimbursed cost.''; and

(3) in subparagraph (C)—

(A) by striking ''an election by the State under subparagraph (A)'' and inserting ''the application of subparagraph (A)'';

(B) by inserting ''or be lawfully present'' after ''lawfully reside''; and

(C) by inserting ''or present'' after ''lawfully residing'' each place it appears.

(b) CHIP.—Subparagraph (O) of section 2107(e)(1) of the Social Security Act (42 U.S.C. 1397gg(e)(1)) is amended to read as follows:

''(O) Paragraph (4) of section 1903(v) (relating to lawfully residing individuals).''.

(c) EFFECTIVE DATE.—

(1) IN GENERAL.—Except as provided in paragraph (2), the amendments made by this section shall take effect on the date of enactment of this Act and shall apply to services furnished on or after the date that is 90 days after such date of enactment.

(2) EXCEPTION IF STATE LEGISLATION REQUIRED.—In the case of a State plan for medical assistance under title XIX, or a State child health plan under title XXI, of the Social Security Act which the Secretary of Health and Human Services determines requires State legislation (other than legislation appropriating funds) in order for the plan to meet the additional requirements imposed by the amendments made by this section, the respective State plan shall not be regarded as failing to comply with the re-

quirements of such title solely on the basis of its failure to meet these additional requirements before the first day of the first calendar quarter beginning after the close of the first regular session of the State legislature that begins after the date of enactment of this Act. For purposes of the previous sentence, in the case of a State that has a 2-year legislative session, each year of such session shall be deemed to be a separate regular session of the State legislature.

SEC. 4. CONSISTENCY IN HEALTH INSURANCE COVERAGE FOR INDIVIDUALS WITH FEDERALLY AUTHORIZED PRESENCE, INCLUDING DEFERRED ACTION.

(a) IN GENERAL.—For purposes of eligibility under any of the provisions described in subsection (b), all individuals granted federally authorized presence in the United States shall be considered to be lawfully present in the United States.

(b) PROVISIONS DESCRIBED.—The provisions described in this subsection are the following:

(1) EXCHANGE ELIGIBILITY.—Section 1411 of the Patient Protection and Affordable Care Act (42 U.S.C. 18031).

(2) REDUCED COST-SHARING ELIGIBILITY.—Section 1402 of the Patient Protection and Affordable Care Act (42 U.S.C. 18071).

(3) PREMIUM SUBSIDY ELIGIBILITY.—Section 36B of the Internal Revenue Code of 1986 (26 U.S.C. 36B).

(4) MEDICAID AND CHIP ELIGIBILITY.—Titles XIX and XXI of the Social Security Act, including under section 1903(v) of such Act (42 U.S.C. 1396b(v)).

(c) EFFECTIVE DATE.—

(1) IN GENERAL.—Subsection (a) shall take effect on the date of enactment of this Act.

(2) TRANSITION THROUGH SPECIAL ENROLLMENT PERIOD.—In the case of an individual described in subsection (a) who, before the first day of the first annual open enrollment period under subparagraph (B) of section 1311(c)(6) of the Patient Protection and Affordable Care Act (42 U.S.C. 18031(c)(6)) beginning after the date of enactment of this Act, is granted federally authorized presence in the United States and who, as a result of such subsection, qualifies for a subsidy under a provision described in paragraph (2) or (3) of subsection (b), the Secretary of Health and Human Services shall

establish a special enrollment period under subparagraph (C) of such section 1311(c)(6) during which such individual may enroll in qualified health plans through Exchanges under title I of the Patient Protection and Affordable Care Act and qualify for such a subsidy. For such an individual who has been granted federally authorized presence in the United States as of the date of enactment of this Act, such special enrollment period shall begin not later than 90 days after such date of enactment. Nothing in this paragraph shall be construed as affecting the authority of the Secretary to establish additional special enrollment periods under such subparagraph (C).

SEC. 5. REMOVING CITIZENSHIP AND IMMIGRATION BARRIERS TO ACCESS TO AFFORDABLE HEALTH CARE UNDER THE ACA.

(a) IN GENERAL.—

(1) PREMIUM TAX CREDITS.—Section 36B of the Internal Revenue Code of 1986 is amended—

(A) in subsection (c)(1)(B)—

(i) by amending the heading to read as follows: ''SPECIAL RULE FOR CERTAIN INDIVIDUALS INELIGIBLE FOR MEDICAID DUE TO STATUS''; and

(ii) by amending clause (ii) to read as follows:

''(ii) the taxpayer is a noncitizen who is not eligible for the Medicaid program under title XIX of the Social Security Act by reason of the individual's immigration status,''.

(B) by striking subsection (e).

(2) COST-SHARING REDUCTIONS.—Section 1402 of the Patient Protection and Affordable Care Act (42 U.S.C. 18071) is amended by striking subsection (e) and redesignating subsection (f) as subsection (e).

(3) BASIC HEALTH PROGRAM ELIGIBILITY.—Section 1331(e)(1)(B) of the Patient Protection and Affordable Care Act (42 U.S.C. 18051(e)(1)(B)) is amended by striking ''lawfully present in the United States,''.

(4) RESTRICTIONS ON FEDERAL PAYMENTS.—Section 1412 of the Patient Protection and Affordable Care Act (42 U.S.C. 18082) is amended by striking subsection (d) and redesignating subsection (e) as subsection (d).

(5) REQUIREMENT TO MAINTAIN MINIMUM ESSENTIAL COVERAGE.—Subsection (d) of section

5000A of the Internal Revenue Code of 1986 is amended by striking paragraph (3) and by redesignating paragraph (4) as paragraph (3).

(b) CONFORMING AMENDMENTS.—

(1) ESTABLISHMENT OF PROGRAM.—Section 1411(a) of the Patient Protection and Affordable Care Act (42 U.S.C. 18081(a)) is amended by striking paragraph (1) and redesignating paragraphs (2), (3), and (4) as paragraphs (1), (2), and (3), respectively.

(2) QUALIFIED INDIVIDUALS.—Section 1312(f) of the Patient Protection and Affordable Care Act (42 U.S.C. 18032(f)) is amended—

(A) in the heading, by striking ''; ACCESS LIMITED TO CITIZENS AND LAWFUL RESIDENTS''; and

(B) by striking paragraph (3).

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to years, plan years, and taxable years, as applicable, beginning after December 31, 2021.

SEC. 6. PRESERVING ACCESS TO COVERAGE.

(a) IN GENERAL.—Nothing in this Act, including the amendments made by this Act, shall prevent lawfully present noncitizens who are ineligible for full benefits under the Medicaid program under title XIX of the Social

Security Act from securing a credit for which such lawfully present noncitizens would be eligible under section 36B(c)(1)(B) of the Internal Revenue Code of 1986 and under the Medicaid provisions for lawfully present noncitizens, as in effect on the date prior to the date of enactment of this Act.

(b) DEFINITION.—For purposes of subsection (a), the term ''full benefits'' means, with respect to an individual and State, medical assistance for all services covered under the State plan under title XIX of the Social Security Act that is not less in amount, duration, or scope, or is determined by the Secretary of Health and Human Services to be substantially equivalent to the medical assistance available for an individual described in section 1902(a)(10)(A)(i) of the Social Security Act (42 U.S.C. 1396a(a)(10)(A)(i)).

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